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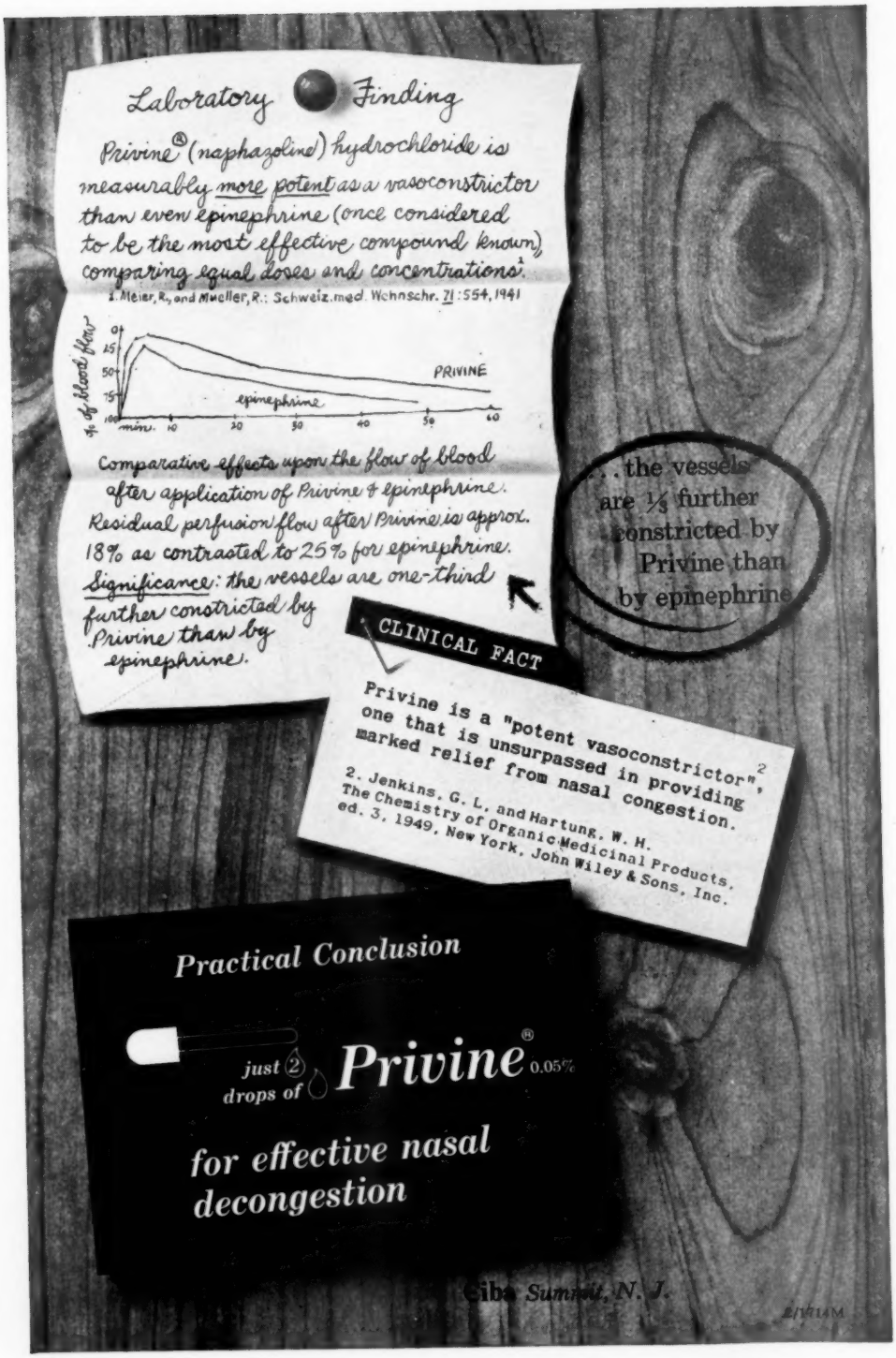
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2. Jenkins, G. L. and Hartung, W. H. The Chemistry of Organic Medicinal Products, ed. 3, 1949, New York, John Wiley & Sons, Inc.
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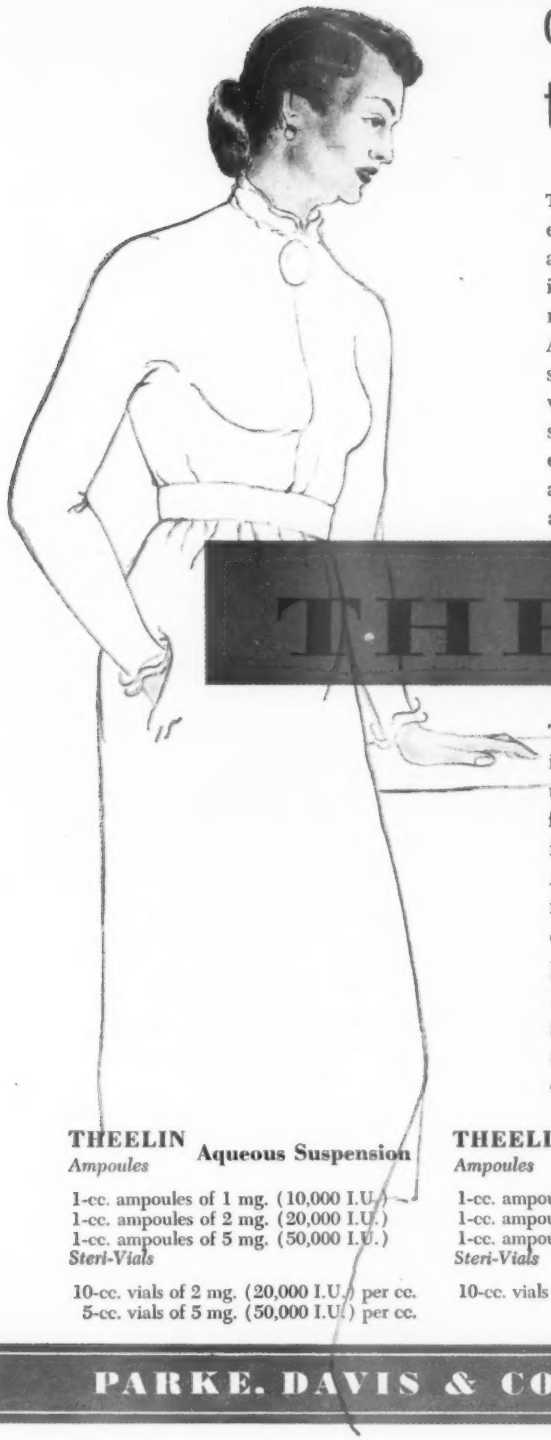

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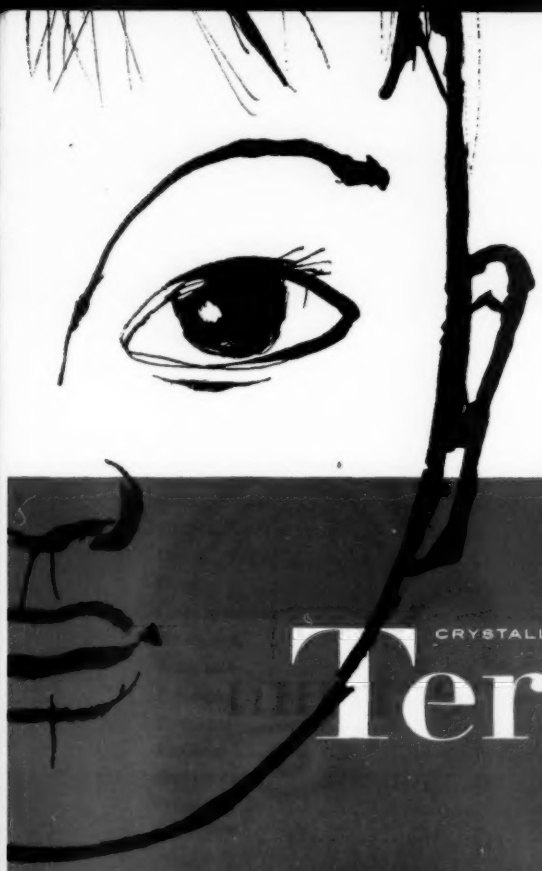

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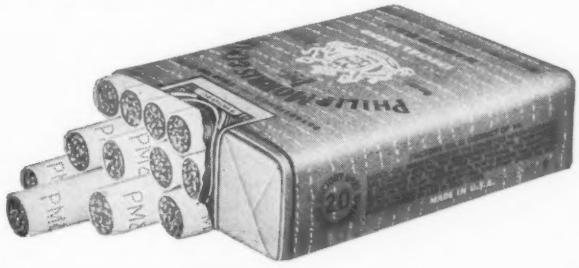

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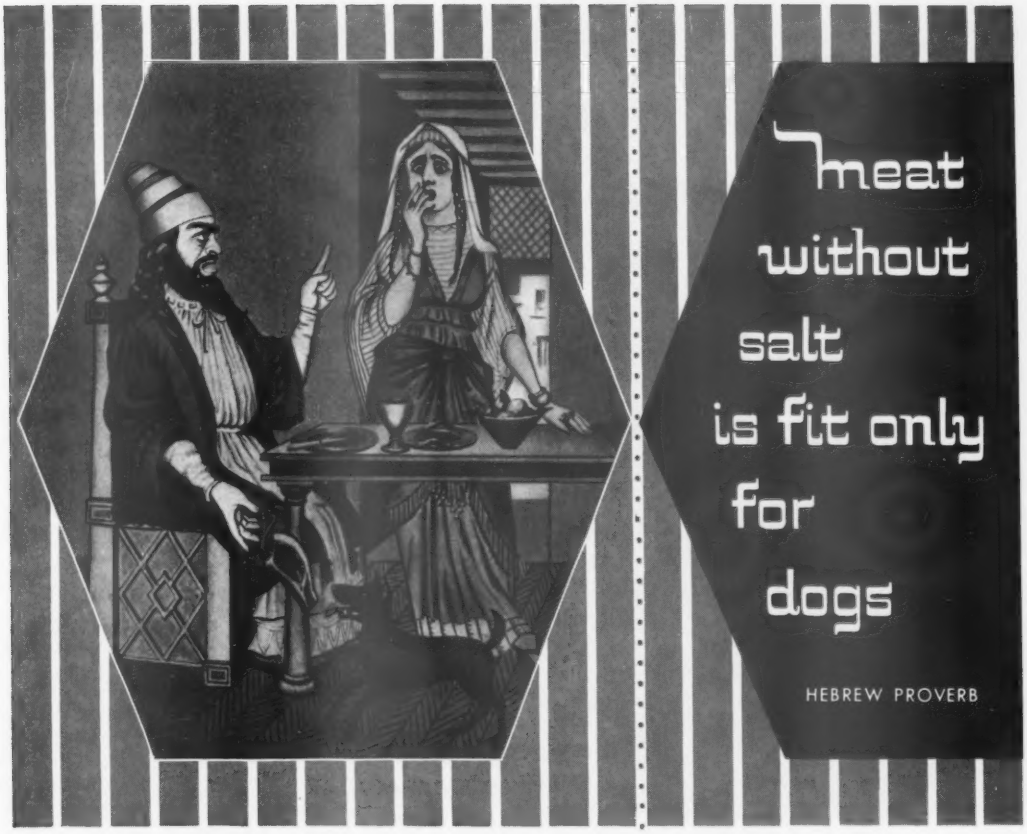

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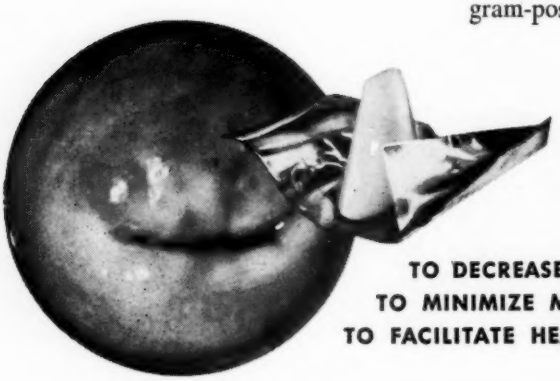

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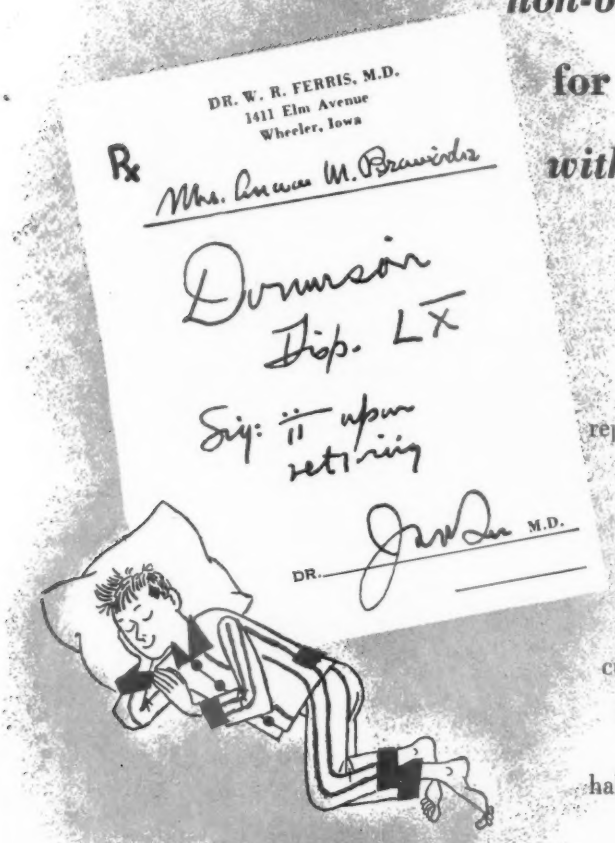

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Evolution in the Field of Medical Care

Ellen C. Potter, M.D.

THE MID-CENTURY stimulates "stock-taking," not only in business but in education, health, and welfare, as is evidenced by the mid-century White House Conference on Children and Youth.

It is, therefore, in order that we in the field of medical care should look back along the road medical service has traveled in the last one hundred years in order to chart our course for the future.

This is particularly true for women in medicine, thanks to the Blackwell sisters who, under great handicaps, first proved that women were capable of absorbing medical education and successfully practicing the art of ministering to the sick. In addition, we acknowledge our debt to good Quaker men who, stimulated by the demands of good Quaker women, in 1850 created the Woman's Medical College of Pennsylvania to insure that the door would always stand open to women who were qualified and who desired to enter the profession.

Scientific Medicine

Scientific medicine had not yet come into being in 1850, but by 1860 there were in existence 62 medical schools, with scant entrance requirements and lacking what we now call "teaching hospitals," and with no clinical laboratories. "Diploma mills," where a diploma could be "purchased" but not "earned," came into being in the West in the 1870's, and those holding these diplomas were accepted by licensing boards (where such existed) without examination.

There were only 178 hospitals in the United States, according to the first census taken in 1873, as contrasted with the 6,572 as of 1950, not all of which are qualified, even today, as "teaching hospitals" and not all of which include women on the staff.

In those early years of the 1850's the medical student entered his profession with only a smattering of scientific medicine. His eyes, ears, and fingertips were his chief diagnostic equipment. There were no instruments of precision to measure blood pressure, no electrocardiography; no clinical laboratory with all its diagnostic aids; no x-ray for diagnostic or treatment purposes. (Roentgen was only six years old in 1850.)

Very little was known as to bacterial infections. The microscope had little to offer. Viruses were unheard of. And hormones, antibiotics, vitamins, and the miracle drugs of today, which we take for granted, were not dreamed of.

The surgical procedures on lungs, heart, brain, and much of the major general surgery, as we know it today, were not thought to be possible even up to the turn of the twentieth century. The emphasis in education in those early days was on the practice of general medicine, very largely rendered in the patient's home.

For the "lunatic" of a century ago there was little hope and less treatment. Dorothea Lynd Dix was pounding on the doors of reluctant governments asking for humane custody in institutions for these hopeless beings. Today, psychiatry has opened the

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door to early diagnosis, prevention, and cure of mental disorders. We recognize psychosomatic disorders, and know that a healthy mind in a healthy body is essential if democracy is to survive.

The physician was paid for his service in cash or "in kind" or not at all, even by the overseer of the poor, who felt that the physician's service was his contribution to charity.

Public Health

In the field of public health, in the early 1850's, the Marine Hospital Service (subsequently the United States Public Health Service) was in being with limited functions. Prior to the establishment of boards of health under public auspices, matters relating to health and sanitation, in most states, were discussed by state medical associations, and reports were sent to them by district and county societies in regard to epidemics and sanitary conditions.

The major responsibility of public health departments, state or local, as they developed, was the control of epidemics and environmental sanitation. Vital statistics, as we know them today, left much to be desired.

In substance, then, the skill of the medical practitioner was applied to the care of the sick chiefly in his own home and he was in truth the "family doctor," a friend of the family and its counselor.

The specialist had not yet arrived, and not until 1917 was the first specialty board established, in ophthalmology.

Where Do We Stand Today?

In medical education we can proudly say we provide in this country the best in the world. Our 72 medical schools, approved by the Council on Medical Education, had an enrollment of 25,633 students in the school year of 1950-51; they graduated a total of 6,135 students, of which number 468 were women (7.6 percent of all graduates). There were but three of the 72 schools in which no women were enrolled. (The first class graduated by the Woman's Medical College in 1852 numbered eight.)

Medical graduates today, men and women, are disciplined in the medical sciences, skilled in diagnostic procedure and the art of ministering to the sick. The specialty boards have multiplied, and their combined certified memberships exceed greatly in number those certified in internal medicine, which is, after all, the backbone of medical care.

These facts suggest that for the future we must think in terms of "group practice," if the sick man is not to find himself divided into segments unrelated to each other, or to him. We cannot afford to lose the touch of the family doctor, but we also need the specialist. There is need for the "medical team," utilizing the skills of the medical social worker as an ally of the practitioner.

Our hospital service is of excellent quality, especially when associated with medical schools, but the distribution of hospitals leaves much to be desired, particularly in suburban and rural areas. The suggestions offered by Dr. Thomas Parran, formerly Surgeon General of the United States Public Health Service, have great merit, that is, creating the rural health center, feeding its more serious medical cases into the rural small hospital for internal medical care, or, in case of major seriousness, into the larger district hospital for major surgery, and so on, or finally, into the base hospital in a metropolitan center where teaching, research, and consultation services are available.

This type of coordinated and correlated services affords also an educational refresher experience to all physicians in the area.

We must be a party to such development.

The training of the professional teams. The training of nurses, which had its inception in the 1870's, first on hospital wards and later on the university level, has provided the physician with an ally serving him well in the operating room, on the wards, and in the homes of his patients. Today, it becomes evident that the program of nursing education needs re-vamping if the coverage of all the needs of the people are to be met. We cannot dispense with the nurse qualified as teacher, administrator, technician in special fields, but we need also the trained and qualified bedside nurse (call her practical nurse, if you choose), whose time is devoted to the patient. The lack of their services creates one of the acute problems today in home and hospital care of the sick.

In addition, we welcome the inclusion, on our technical teams, of the trained hospital administrator, the professional medical social worker, and the multitude of trained technicians in many fields who implement the service of the physician in his practice and the hospital in its total service to the patient.

In public health the evolution in the last half century has progressed with great speed; communicable diseases have been in large measure prevented or controlled; maternal and infant mortality have diminished, thanks to the stimulus and guidance of the Federal Children's Bureau. School health programs, both educational and diagnostic, under the administration of the school system and sometimes assisted by the health department have by their united impact increased life expectancy for millions, whom, in turn, we now find swelling the ranks of the aging and increasing the incidence of "long

term illness." (We women should be alerted to the fact that we exceed the men in longevity.)

For the prevention of long term illness and for the treatment and care of those permanently and completely disabled, adequate programs have been devised but not yet generally adopted. (Federal funds have just been made available for medical service to the latter group and state-wide plans are in the making to implement the program before 1953.) All the facilities in the fields of public health and all branches of the healing arts will be involved, hopefully, in this great adventure.

Rehabilitation

The casualties of two great wars, the accidents in industry, on the highways, in the air, on the railroads, in the home, and on the farm, and the need to salvage this human wreckage, have brought into being the imaginative, almost miraculous rehabilitative programs which give hope of complete rehabilitation to many, and to others, less fortunate, a realization that, within the limits of the given handicap, he or she may lead a useful life.

The Economics of Medical Care

Medical charity in the old days was accepted as a matter of course; philanthropists established hospitals; physicians gave their services in large measure; government, locally, gave grudgingly, if at all, when the indigent were to be served.

We did not recognize the problems of the medically indigent, (that is, the person who can get along and pay his bills until severe illness strikes) until within the last twenty years. Insurance in various forms has to a large extent minimized the financial problem for patients, for hospitals, and for physicians. Government itself, by various methods and under Federal Social Security programs, has recognized its obligations in the acute and chronic fields of medical need, but the rendering of service leaves much to be desired.

The Maintenance of Health

The conception of the function of the physician in relation to his patient and the function of public health services in relation to the citizen have undergone great change in the last half century.

Today the maintenance of health, as contrasted with curing the sick, is of paramount importance. Well baby clinics, perhaps, kindled by the Federal Children's Bureau, which recognized that the strength of a nation is dependent upon the physical, mental, and emotional strength of its people, may be said to have lighted the candle following World War I.

The Joint Statement of the four great national organizations in health and welfare, the American Medical Association, American Hospital Association, American Public Health Association, and American Public Welfare Association, (published in 1947) says:

> The success of programs to conserve the health of infants and children suggests the possibility of achieving effective health programs directed to adolescents as well as adults. The health programs of our high schools and colleges, including medical examinations and correction of defects, physical fitness and recreational programs, and health education require intensive development.
>
> The periodic medical examination of apparently well persons needs to be explored on a new basis, including selective laboratory and clinical examinations chosen for particular age, sex, geographical and occupational groups. These include serological, chest x-ray, urinalysis, electrocardiography, ophthalmoscopic and other examinations.

It is on this basis that the attack upon long term illness can be made effective and such diseases can be prevented.

Medical Care in the Future

The highly specialized nature of scientific medical practice raises a serious question as to whether the "solo" practice of medicine can long endure. Dr. Dean A. Clark, General Director of the Massachusetts General Hospital and formerly the Medical Director of the Health Insurance Plan of Greater New York, says: "A pattern of professional organization which will weld the multitudinous parts of health and medical services into a smoothly functioning whole is as important as the consumer's means for paying for these services. Among the methods of professional organization gaining in popularity and spreading throughout the country is that of group practice."

Five hundred or more such groups are now in operation. Some of these groups operate upon the principle of "fee for service," as for example, the Mayo, Lahey, and University of Chicago clinics, but they do not assume responsibility for the total medical needs of the family. Other groups do provide for the whole family on the fee for service basis.

A shining example of the combination of group practice with the pre-payment insurance plan, covering the family and providing for the maintenance of health as well as medical, surgical, and specialist's care, is to be found in the Health Insurance Plan of Greater New York, which serves more than a quarter million persons through twenty-eight medical groups, totaling 750 physicians, in defined areas throughout the city. The backbone of the service is the general practitioner, associated with qualified specialists in the twelve basic specialties now recognized.

One last word on the subject of medical care should make note of the existence of the Inter-Association Committee on Health.

We have in this voluntary organization a compact body composed of three appointed delegates approved by each of the six major national organizations concerned with the problems of health and sickness and the financing of medical care for the indigent: The American Dental Association; the American Hospital Association; the American Medical Association; the American Nurses' Association; the American Public Health Association; and the American Public Welfare Association. Their search is for the common denominators of agreement among these associations on the basis of which sound programs relating to medical care, health maintenance, and the financing and administration of such service to the American people may be rendered.

We, who are members of the medical profession, have a great opportunity as citizens to promote the evolution of medical care and health maintenance for all the people. Let us not miss the opportunity which the next fifty years will present.

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Development of the Child Health Conference Program in Pittsburgh

By Anne B. Wagner, M.D.

A PROGRAM providing medical and nursing service for the well child has existed in Pittsburgh for approximately thirty years. Service in this field has been offered chiefly by two agencies, the Bureau of Child Welfare of the Department of Health, and the Visiting Nurse Association. During periods of economic depression new conferences tended to appear under the sponsorship of a variety of voluntary agencies, with the purpose of providing free milk for infants and for preschool children, in addition to giving health supervision. As normal economic conditions returned, these conferences gradually ceased operations, so that the only continuing programs have been those of the Public Health Department and of the Visiting Nurse Association.

These two agencies formerly worked in complete independence of each other. The well baby clinics administered by the Department of Health were staffed by school doctors and school nurses; the Visiting Nurse Association Conferences used nurses engaged in a generalized nursing program, and general medical practitioners in the community.

When the reorganization of the Department of Public Health in Pittsburgh began two years ago, the former Bureau of Child Welfare became the Bureau of School Health Services, and a new bureau was created, the Bureau of Maternal and Pre-School Services. The well baby clinics were then transferred to this bureau, their services were revised, and they were renamed Child Health Conferences. The clinics operated by the Visiting Nurse Association have for the most part either been closed, and the case load transferred to the Department of Health, or they have been turned over to the Bureau of Maternal and Pre-School Services for administration.

Since no written statement of policies or procedures to be followed in the Child Health Conferences had ever been formulated by the Health Department, the first step in revision was joint planning

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by the Bureau of Maternal and Pre-School Services and the Bureau of Public Health Nursing, and preparation of a statement of policies and procedures. It should be noted here that the Bureau of Public Health Nursing is also a product of the reorganization of the Pittsburgh Department of Public Health. Formerly the nurses in the Department of Health were employed for specialized duties by the various bureaus in the Health Department, for example, school health, tuberculosis control, infectious disease control, and so on. These groups of nurses are now combined in the Bureau of Public Health Nursing to do a generalized nursing program.

The planning group defined the objective of the Child Health Conference Program as service centered, and outlined the following functions to achieve their goal of "Happy Healthy Children: Secure Informed Parents."

1. To help parents develop attitudes and acquire information essential to meeting the everyday responsibilities encountered in rearing a child.
2. To help parents accept individual variations in the usual pattern of growth and development and to appreciate that optimum health is a relative factor.
3. To provide those preventive measures which have proved effective in promoting good health and in lessening the incidence of disease among children.
4. To discover variations from healthy development which indicate a need for curative care, to interpret the need for such care, and to assist parents in planning to obtain it.

The Child Health Conference Program of the Health Department in Pittsburgh is tax-supported and, therefore, available to any parent residing within the city. However, considerable effort is made to persuade persons already under private medical care or able to afford private medical care to use that source. The age group covered is from birth to admission to first grade. The aim is to offer services of the Child Health Conference to those persons needing health supervision for their children but unable to provide it from their own financial resources. Children attending a Child Health Conference for the first time, who present some deviation from health requiring curative or specialized medical care, are not admitted, but are referred to a proper source for such care. During the year 1950, 6 percent of the children in Pittsburgh of preschool age were under health supervision in the Child Health Conferences. Since it is generally estimated that, in a city such as Pittsburgh, approximately 40 percent of children in this age group need the services of the Child Health Conference, it is evident that an expansion of the program in Pittsburgh is greatly needed.

Considerable thought is being given to an architectural layout for the Child Health Conference which will lend itself to effective work, particularly with regard to privacy for physician-parent and nurse-parent interviews and to making the flow of patients smooth and orderly. Most conferences are housed in whatever facilities are available, for example, school buildings, housing projects, settlement houses, and so on. Considerable ingenuity is often required to arrange the available quarters in a way that permits efficient operation.

In only one area of the city is there a district health center with all the physical features considered desirable in the ideal Child Health Conference. These include a reception and waiting room, dressing and weighing room, rooms for consultations between physician and parent and nurses and parents, and play areas—one for toddlers and one for older children. Recent additions to this conference are a crib and a playpen where infants may be placed while the mother confers with doctor or nurse.

The traditional functions of the Child Health Conference, physical examinations, feeding instruction, and immunizations are carried out. In addition, the psychological aspects of child rearing are becoming of increasing importance, as in general pediatric thinking and practice today. Discussion on feeding, sleeping, discipline, behavior, and so on, take a prominent place in the work, especially in attempting to forewarn mothers of the critical points in child rearing at which troubles commonly begin. Because of shortage of public health nurses, visits cannot be made to the homes of all children seen in the Child Health Conferences, but some home visiting is done in selected cases, where further knowledge of the home situation seems necessary in order to give intelligent service, or when it seems probable that the parent could benefit from guidance or demonstration of some phase of child care given in the home setting.

Frequency of visits to the Child Health Conference is regulated by the need for supervision, as determined by the physical progress of the child and by attitudes and relationships observed in the Child Health Conference and in the home. The usual procedure is to see the infant once a month during the first year, and then gradually to lengthen the interval between visits to several months. A policy of flexibility is maintained, however; a secure mother with a normal healthy infant may be asked to return at six to eight week intervals; an emotionally disturbed older child may be seen monthly or oftener, at the direction of the physician.

It was realized early in the revision of the Child Health Conferences that the existing record forms were outmoded and inadequate. A new record system was, therefore, planned and instituted as an aid to consistent analytical service to the child and to his parents. The new records consist of:

A. An individual folder for each child, whereon are listed (1) identifying data for that child, (2) a brief family history, noting particularly any factors which may have a bearing on the child's medical status, (3) history of the pregnancy, (4) the child's medical history (including a feeding history), (5) a maturation record, (6) immunization record, (7) positive physical findings, (8) recommendations by the physician, and nurse's notes.

B. A family roster and social data record, with names of all members of the family and information concerning their health, occupation, economic status, and so on.

C. A family progress section which contains the record of the public health nurse's services to the child and his family.

D. A simple baby record book for recording the doctor's instructions, immunizations performed, and so on. This booklet is retained by the mother and brought to the conference at each visit.

The first three portions of the records are kept in a family folder in the Records Room, along with such other records as may exist for any member of the family receiving service through any other bureau in the Health Department, thus making available to the staff in one central location all records for each family served (excepting school health records). Records to be used for any session are requisitioned from the Records Room and returned there after the conference session.

At the close of each conference session, when time permits, the physicians and nurses sit down together for a round table discussion of the points of interest in the cases seen during the session. This device has proved most helpful in stimulating a free interchange of ideas between the various members of the conference team, welding them more closely together, and producing greater unity of thought and action. At this time administrative policies are discussed and changes suggested to keep the conferences abreast of new developments. Periodic meetings of all physicians serving the Child Health Conferences, and of physicians and nurses are held to further the same purposes.

The staff physicians in the conferences are either pediatricians or physicians with some pediatric training. The nurses are public health nurses employed either by the Department of Public Health or the Visiting Nurse Association. Clerical aid is provided for the most part by the Department of Public Health, but a few conferences receive clerical service and hostess service from volunteers.

One conference session in the district health center has been designated as a training session. In this conference, staff nurses of the Bureau of Public Health Nursing and the Visiting Nurse Association serve for a four to six-month period under the supervision of nurses especially skilled in Child Health Conference work. At this session also a pediatrics resident from Children's Hospital works for a three-month period under the supervision of a staff physician. Dental examinations and health education in dentistry are provided by the Professor of Child Dentistry from the University of Pittsburgh Dental School. Consultation service for the staff is available through consultants in maternal and child health, nutrition, and mental health. The most recent addition to this consultation service is a corps of psychologists, psychiatrists, and a psychiatric case worker from the University of Pittsburgh Medical School, Department of Psychiatry.

Plans for the future include:

1. A continuing effort to provide more adequate housing for conferences in many of the areas served.
2. Extension of service to areas of low economic level.
3. Providing a source for service and observational experience for medical and nursing students.
4. Parent discussion groups. We feel that many phases of child care could be taught to groups of parents as effectively as to individual parents. Group methods would enable us to reach a greater percentage of our population without greatly increasing the number of nurses and doctors now working in the program.
5. Continuing appraisal of all elements of the program, comparison with well child services in other areas, and an attempt to evaluate the results of this type of child care.

Summary

A brief history of well child care in Pittsburgh through public health sources is presented, followed by an exposition of recent developments in this type of health supervision. The present Child Health Conference Program is described, and plans for future development are listed.

Heart Disease is a Public Health Problem

Mary L. Richardson, M.D.

SAFEGUARDING the health of the people by all known skills is the function of the state health department. High on the list of public health problems is heart disease control.

In the early days of our country, public health activities were directed primarily to control of contagious diseases. Out of these first attempts the protection of water supply and environmental sanitation developed. Vaccination for smallpox at the end of the eighteenth century was the beginning of immunization against communicable infections. Now, after little more than one hundred years, because of successful immunization and the control measures assured by public health laboratory procedures, the more serious of the infectious diseases have been all but eliminated.

With contagious diseases well under control, public health interests extend to other preventive fields. The teaching of preventive medicine in medical colleges, lay education in prevention of sickness and death, the development of a way of life that insures the best in physical, mental, and spiritual well-being, have brought the individual as well as his environment into the limelight.

Actual prevention of disease and promotion of health of the individual are essentially the function of each practitioner of medicine in the community. Public health activities should supplement or complement his effort.

With the growth of public interest in national health affairs, with the increase of scientific knowledge gained through research, with more precise control measures available, the medical profession, in cooperation with state health departments, should be able to work out a unified plan of health promotion and protection. Such a plan is at present being actively developed in heart disease.

Heart disease affects to some degree practically every family in this country. No age is exempt. We find congenital lesions in the infant, rheumatic heart disease in the child and young adult, arteriosclerosis in the aging. No family escapes completely the consequences of these diseases.

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Because of the chronic nature of heart disease and its far-reaching social and economic effects, the private physician needs help. The person with heart disease needs help. The community needs help. Public health activities, therefore, should be centered on assisting physicians, hospitals, and clinics to provide the best possible complete care of heart patients, utilizing all the resources of the community towards this end, for heart disease is a major public health problem.

We know that, with the diagnosis made early in the course of the disease and with the patient understanding his limitations and putting himself under suitable medical supervision, there is every chance that his life can be prolonged and invalidism prevented. Every effort must be made to return the patient to a productive and independent place in the community. Program planning to this end needs the cooperation of community physicians and the state health department, planning that should include case finding, education, prevention, and rehabilitation.

The community needs adequate facilities for diagnosis and consultation. This need can be supplied by state clinics where the services of a cardiologist and where laboratory and x-ray facilities can be made available to the community physicians.

Education is an outstanding need in this program. Postgraduate training for the physician, general health education, special courses for nurses, special courses for patients themselves, all are necessary to make a program successful.

There must be education of management and union leaders, showing them statistically that, provided there is proper selective job placement, the cardiac with limited disability can be as productive as any other person.

Very little has been done in the field of rehabilitation of the heart disease patient. Much has been done to aid in recognition of his disabilities but not much toward establishing his capabilities. Individual agencies and individual offices and industries are doing excellent work in this field and, with the cooperation of the state welfare and state health departments, a great deal can be accomplished.

In Pennsylvania, the State Health Department has not as yet developed any formal program in

adult heart disease, but five years ago the Commonwealth of Pennsylvania appropriated funds to aid in the control of rheumatic heart disease. It is recognized that the keystone for any heart disease control program is the family physician. It is also recognized that early detection is basic to the control of heart disease, because treatment, to be most effective, must be applied soon after the trouble begins. To meet this basic need the Pennsylvania State Department of Health has set up 16 clinics in areas selected for the most efficient distribution of their services to the entire commonwealth.

These clinics are restricted to diagnosis and consultations. No charge is made for diagnosis, and any resident of the commonwealth up to 21 years of age is eligible for the service. A complete report of the findings, diagnosis, and recommendations for care and therapy are sent to the referring physician.

Each clinic includes a director, certified by either the Board of Internal Medicine or Pediatrics, especially trained in cardiology. This director examines each patient and sends to the referring physician a complete report of his findings, diagnosis, and recommendations for further care. There are also a medical secretary and state health nurse at each clinic session. Many of the clinics are used as teaching centers for nurses and interns. Clinics are held at regular stated times in hospitals equipped to supply all laboratory tests, roentgenograms, and electrocardiograms needed for complete study of the patient.

All patients in these clinics are seen by appointment only and are referred by the family physician. Whether the patient is referred directly from the office of the family physician or indirectly from the findings on school examinations, the final request for study comes from the family physician.

During the fiscal year, 1950-1951, the state rheumatic fever clinics examined 2,391 patients. Of this number 1,892 were new patients and 499 were re-examinations. One thousand nineteen, or 42.6 percent, were found to have no evidence of rheumatic fever or rheumatic heart disease. One hundred sixty-four, or 6.9 percent, had congenital heart disease. In this congenital heart group more extensive study was requested by the directors for 21 patients. These were, accordingly, sent to special congenital heart clinics, and of this number ten were operated upon; five for patent ductus arteriosis, one for coarctation of the aorta, and four for tetralogy of Fallot.

The ten patients going to surgery were from families unable to meet the cost of the operations. The Rheumatic Fever Division paid for actual hospital costs, but no fee was accepted by the cardiac surgeons.

In the school health program the medical examiner is asked to send to the Rheumatic Fever Division the name and pertinent information of all school children having symptoms or history of rheumatic fever or rheumatic heart disease. About one-third of these were seen in state rheumatic fever clinics upon requests from family physicians. Approximately 50 percent of those examined were found to have no evidence of organic heart disease. A very real service is rendered by the clinics when these children are cleared of the stigmata and fears of heart disease.

School nurses and teachers are helped to use to best advantage the consultative facilities available.

Much, in addition to that done by the Rheumatic Fever Division, is being done by municipal health departments, heart associations, and other health and welfare agencies.

Lately there is increasing demand for help at all ages, and, with increasing research and increasing resources for applying this research, the outlook for control of heart disease is one of hope and encouragement.

Lest we as practicing physicians become so preoccupied with the curative aspects of medicine that we lose sight of the preventive services being rendered by our colleagues in the field of public health, the Editors are devoting this number of the JOURNAL to a consideration of a few of these public health services. We are grateful to Dr. Florence L. Marcus for assembling the interesting papers herewith presented. . . . Ed.

Completed Medicine — Rehabilitation

Nila Kirkpatrick Covalt, M.D.

THE DYNAMIC THERAPY in the treatment of any acute or chronic disease should be treatment of the whole man. It is not enough to make a brilliant diagnosis, or save a life, then send the patient home to vegetate. Such a course of procedure means that only the acute phase of illness has been treated. A patient with a physical disability should be taught to be physically self-sufficient. Assistance should be given to help an individual readjust to any mental trauma which may have occurred as a result of the illness. Many patients need assistance and advice in regard to returning to their previous occupations, or may need to be re-trained for new jobs suited to their remaining capabilities.

When a diagnosis of diabetes mellitus is made, the individual is given a prescribed diet and the indicated amount of insulin; he is taught how to administer the insulin and how to examine his urine. If he has to eat in restaurants, the thoughtful physician helps the patient work out a diet that can be purchased. If the patient commutes to and from employment, the interested physician helps him work out a routine by which he can continue his former occupation and still live safely with his diabetes; or perhaps the physician suggests or helps him work out a change in occupation.

No one expects a diabetic to become a bed patient; yet diabetes is an excellent example of a chronic disease. Every physician makes the effort to train an individual with diabetes to continue living as normal a life as possible within the limitations set up by the disease. What is done routinely for a diabetic patient should be done for patients with other chronic diseases. Certainly this is true of those who have physical disabilities, whether they are static or progressive, and especially is it true of those patients in whom a physical disability may or may not be associated with a chronic disease. Chronic disease and old age are not synonymous terms. Likewise, chronic disease and disability need not be synonymous. Chronic disease and disability become more serious problems at any age when medical care is not completed; when no thought is given to teaching an individual how to care for himself, and no thought is given to teaching him how to live with, and not for, his disability.

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Any patient who has had a cerebral vascular accident can be taught to walk again, if he has the desire to do so.[1] Medical complications which need confine such individuals to bed for the remainder of their lives are rare. While approximately 50 percent of the total group of such patients may require braces to walk, the fact remains that the majority can walk. Only a small percentage need become wheel-chair patients. A very minute number need remain bed patients until they die. Even those patients with varying amounts of mental deterioration can be taught certain rudiments of self care (often including walking with assistance), so that they need not lead a completely vegetative existence for the rest of their lives. Yet, at the present time, the patients who have had cerebral vascular accidents and require complete bed care are numbered into the thousands. They have been sent home and allowed to remain in bed. Their treatment ended when their lives were saved, even though their treatment was not completed.

A similar situation is too prevalent with civilians who have had amputations.[2] Too many amputations are still done with no thought as to the proper site for the amputation in relation to the best fitting prosthesis (or even a prescription for the prosthesis). In fact, once the amputation is healed, too many lower extremity amputees are sent home with no instructions, even in crutch walking. Often, if an amputee acquires a prosthesis, it is still too common an occurrence for him to get it because he has the motivation to go buy one for himself "over the counter," or by mail.* Medical prescriptions for

*To qualify as a certified prosthetist, a fitter must be endorsed by two or more licensed physicians. His character and integrity must be respected locally and professionally, and he must have achieved one or more of the following: (1) Four years of experience in fitting; (2) supervised apprenticeship equal to that under the G.I. Training Program; (3) outstanding professional experience and reputation; (4) two years of study in appliance-fitting, plus one year of actual fitting practice. (Official Registry of Certified Firms and Fitters issued by The American Board for Certification of the Prosthetic and Orthopedic Appliance Industry, Inc., 336 Washington Building, Washington, D. C.) In connection with suction sockets a prosthetist must have attended an approved Veterans Administration school and be certified separately.

prosthesis are still too rare. The amputee may or may not buy the proper one. He quickly finds that the leg does not walk itself. In fact, he finds that the best fitting leg does not fit for long, unless the wise and honest limb fitter explains and makes arrangements for the amputee to return for fittings as often as are necessary during the following three to eighteen months that the stump may continue to reshape itself. Three fittings of a prosthesis will not suffice. Three hours or one week of walking retraining by a limb maker is insufficient time to learn to use an artificial limb correctly.[3] Physical therapy departments where civilian amputees can learn to walk are still too few. Many doctors still do not know they can utilize the service of available departments for prosthetic training.

Amputees in the armed forces in World War II had the advantage of the best possible prosthetic fitting and training. The two veterans of that war who lost parts of all four extremities were successfully fitted and trained and are living useful lives today. The victims of the Korean war will have equal opportunities. Every civilian with the loss of even one extremity should have an equal chance, particularly since there are many thousands more civilian amputees every year than ever occur in a similar time period during any war.[4]

Sometimes patients who have had some type of cardiac disease are advised to "go home and take it easy," or sometimes not advised at all. Taking it easy, without any instructions in graded activity or help in readjusting himself and his job to his physical limitations, keeps many a cardiac patient in bed for the rest of his life, if only through his own fears, or the fears of his relatives. Other cardiac patients without those fears, but with equal lack of instruction, resume occupations or physical activities which are beyond their cardiac tolerance, and quickly break again. What is true of cardiac patients is too often true of tuberculosis patients released from a hospital with their disease arrested but with no plans made for their future.

All the 2,400 paraplegics from World War II[5] had the opportunity to learn physical self care. They also had the opportunity to become economically self-sufficient, if they so desired. Too few similar opportunities are available for the much larger number of civilian paraplegics. The majority of such civilians are doomed to a vegetative life in a hospital, in a nursing institution, or in their own homes, a burden to others, but most of all to themselves. Their lives are continually threatened by the severity of recurrent kidney infections, or the complications from decubiti. Like the hemiplegics, the majority of paraplegics can be taught to walk or even to climb stairs with sufficient skill and endurance to get into cars or buses, and to travel to school or work, if they so desire. Of course, they need proper braces and crutches to do so.

It is unfortunate when civilian individuals with static physical disabilities, such as the hemiplegics, the amputees, the paraplegics, and the victims of poliomyelitis are not physically rehabilitated. The patients with the so-called "degenerative" diseases, such as multiple sclerosis, progressive muscular dystrophies, or various other neurological diseases, are more unfortunate, since their routine instructions usually include the advice to "go home and sit, (since nothing else can be done)." Complete treatment, which is the philosophy of rehabilitation, implies that every patient use his remaining physical capabilities as well as his mental facilities for as long as it is possible. No patient should be offered false hope, but neither should he be doomed to hopelessness. Many helpless individuals may sit or lie in bed for years. It is quite likely that, with the progress of medical knowledge, some of them so doomed today may have a cure found for them in a not too distant future.

All of these patients should be taught self care to the maximum of their remaining capabilities. Training in self care has come to be known as training in "Activities of Daily Living" (A.D.L.) and is the goal of physical rehabilitation.[6]

It is the training, or re-training, in the routines that every healthy individual does daily without thinking, as he gets out of bed in the morning, bathes, dresses, shaves (or applies cosmetics), eats, walks down the steps to his automobile, to a bus, or to the subway to work, crosses city streets, carries on his routine job, and returns home at night, where eventually he again retires to bed, with no conscious thought given to all the acts he has performed in doing the simple routine things required in an ordinary day.

Activities of Daily Living can be totaled from 100 to 150 individual items. Charts have been developed to test and keep a record of the individual patient activities. One such chart is shown on the opposite page.

Patients are tested for each item and given a grade and mark, if they can do it independently on the first test. They are then given training (or drill) in those activities which they are unable to do. Oftentimes practice may need to be continued for several weeks until continued re-grading shows that the patient can accomplish the various items with maximum independence, or there may be some activities in which the maximum results have been reached but he will always need help to perform those procedures. Being able to perform the simple acts of daily living, even with handicaps, makes the differ-

PM & R. No._____

STATE OF CONNECTICUT
HOSPITAL FOR CHRONIC ILLNESS
DEPARTMENT OF PHYSICAL MEDICINE AND REHABILITATION

Commission _____ (Status)

Hospital _____

ACTIVITIES OF DAILY LIVING
FUNCTIONAL EVALUATION FOR SELF CARE

Hospital Case No. _____

Name _____ Age ____ Diag _____ Room ____ Bed ____

Method of Recording FIRST TEST:
(1) If activity can be done it is blocked in with black pencil. The date of test is recorded.
(2) If activity cannot be done, the block is left blank.

Method of Recording ACCOMPLISHMENT:
(1) When activity can be done it is blocked in RED, except in training with use of prosthesis when it is blocked in GREEN.
(2) A red mark (or green) is given as soon as grade reaches 50% (Fair).
(3) Date of accomplishment is recorded in date column beside red (green) mark.

Method of GRADING:
(1) Grading is recorded according to the KEY.
(2) Repeated tests and grades are inserted in spaces specified. Repeated tests with dates indicate maximum accomplishments possible over specified periods of time.
(3) Grade sheets of another color are inserted to grade progress in use of prostheses and braces after appliances are procured. Brace progress is recorded in RED; progress in prosthesis training is recorded in GREEN on these inserts.
(4) An X across a color block indicates regression. Reason for this is explained with date, under REMARKS.
(5) When progress again noted, * will show at grade and under REMARKS.

Key to GRADING:

100% N	(Normal) completely independent.
90% G+	(Good Plus) activity adequate and practical, but limited to special style for independence, special height chair, special method of getting out of chair, etc.
75% G	(Good) adequate for practical use but not with sufficient agility or sufficient repetitions.
70% G −	(Good Minus) independent performance beyond mere adequacy but not quite complete security, coordination, balance or endurance.
50% F	(Fair) activity possible, but not practical. Must have assistance, either physical or verbal to complete.
25% P	(Poor) partial activity, cannot complete.
10% T	(Trace) only initiates activity, completes no part.
0% O	(Zero) activity impossible.

The additional small letters beside any of the above grades indicate:
x not indicated for testing.
t probably trainable.
w can do only from wheel chair.
c can do only with crutches, 1 or 2 specifies number of each.
cc can do only with canes, 1 or 2 specifies number of each.
s can only do standing.
b possible only in bed.
Circle around letters — can do only with some apparatus (i.e. braces, special forks, etc.)

TABULATED RESULTS:
If desired, can grade each of 11 main groups of activities by percentage average, and then average total percent.

REMARKS:
Necessary explanations are recorded at end of test sheet. * at grade or date indicates explanation has been written in appropriate place.

ACTIVITY	1st (Self) Test	Date	Accomplishment	Date	Initials	GRADED ACTIVITY ACCOMPLISHMENTS							
						Grade	Date	Grade	Date	Grade	Date	Grade	Initials
I. NON-WALKING													
A. BED													
Moving from place to place in bed													
Roll to right side, then to left													
Turn and lie on abdomen													
Sit erect													
Operate signal light													
Operate bed lamp and radio													
Procure object from night table													
Hold book													
Turn pages of book													
Turn pages of newspaper													
Put on — remove pajama top													
Put on — remove pajama pants													
Wind wrist watch													
Strike match													
Open and close safety pin													
B. HYGIENE													←Grade
Use handkerchief													
Wash hands													
Wash face													
Wash extremities													
Brush or comb hair													
Brush teeth													
Shave (Women—put on cosmetics)													
Clean finger nails													
Trim finger nails													
Trim toe nails													
Get on and off bed pan													
Use toilet paper													
C. EATING													←Grade
Eat with fingers													
Butter bread													
Eat with fork													
Eat with teaspoon and stir coffee													
Eat with soup spoon													
Cut meat with knife													
Use both knife and fork													
Drink from glass													
Drink from cup													
													←Grade

Additional activities are listed on pages 2, 3, and 4 of this chart: D. Dressing, E. Utilities, F. Communication, G. Apparatus, and

II. LOCOMOTION AND AMBULATION

A. Wheelchair, B. Bathroom, C. Standing to Walking, D. Travelling.

Copies of this chart are available on request to Hospital for Chronic Illness, Rocky Hill, Conn.

CI-PMR-1064

ence between being physically helpless or being a physically self-sufficient individual.

The hemiplegic patient still has one good arm and one good leg. He can learn to move about in bed and to turn in bed. His bedside table can be placed so that he can reach a glass of water himself, without calling a nurse or relative to hand him the glass of water and hold it up to his lips many times during the day or night. He can be taught to dress, shave, eat, tie his tie, button his shirt, and tie his shoes with one hand. The more relatives, helpful nurses, and doctors perform these simple acts, the more rapidly an individual forgets he has a remaining normal arm and leg. He accepts complete service and rapidly loses any ability to help himself. The more helpless he becomes, or permits himself to become, the more self-respect he loses. The more he is delayed in being taught to do these simple things, the more difficult he will consider it to get from bed to chair or wheel chair, to push a wheel chair, or to learn to walk. This is true for patients with all types of obvious physical disabilities. It can be equally true for those with chronic disease but without any obvious physical evidence of disability.

There are no specific rules or technique, except that from the standpoint of body mechanics certain methods should work best with each disability. The hemiplegic gets from bed to chair in one manner; the amputee does it in another; the paraplegic accomplishes it in a still different fashion. A little "know how" makes it possible for any interested individual to help such patients achieve self care.

It is difficult for a physically self-sufficient individual to visualize himself as suddenly paralyzed in one arm or one leg, or in both legs, or to be suddenly without one or both legs or arms. Functional training can be instituted by any individual who has a conception of the physical goals to be attained, and who will try to imagine himself with a similar disability and analyze how he could extricate himself from similar situations, be it to reach for a glass of water or to get out of bed with a paralyzed arm and leg. Every activity done for self care is simply attention to the common sense little things, put together in proper order.

There are insufficient physical and occupational therapists to initiate this training under the guidance of physiatrists (equally insufficient). Such individuals, with special training in kinesiology and body mechanics can more easily analyze the procedure, but anyone can analyze them, if he has a little vision and a little "know how," up to the point of learning crutch walking and walking on prosthesis or with braces.

Walking re-training is more easily taught in parallel bars than in walkers. Crutches must be fitted correctly. Physical therapists, who will instruct interested individuals in walking and crutch techniques, are available for consultation in any hospital or community.† Physiatrists from physical medicine and rehabilitation centers are available for consultation also. Courses are offered in at least two centers in this country where civilians may learn to teach Activities of Daily Living.‡

Without such training, but with common sense and thought, much can be done for many patients. Sometimes a simple adaptive gadget is all that is necessary for a patient to feed or dress himself. For example, a hook, of the type used to hang up cups, attached to a stick, will enable a patient to put on his underwear, trousers, socks, and shoes, if he is unable to bend at the waist. Other easily made gadgets are shown in the illustrations.

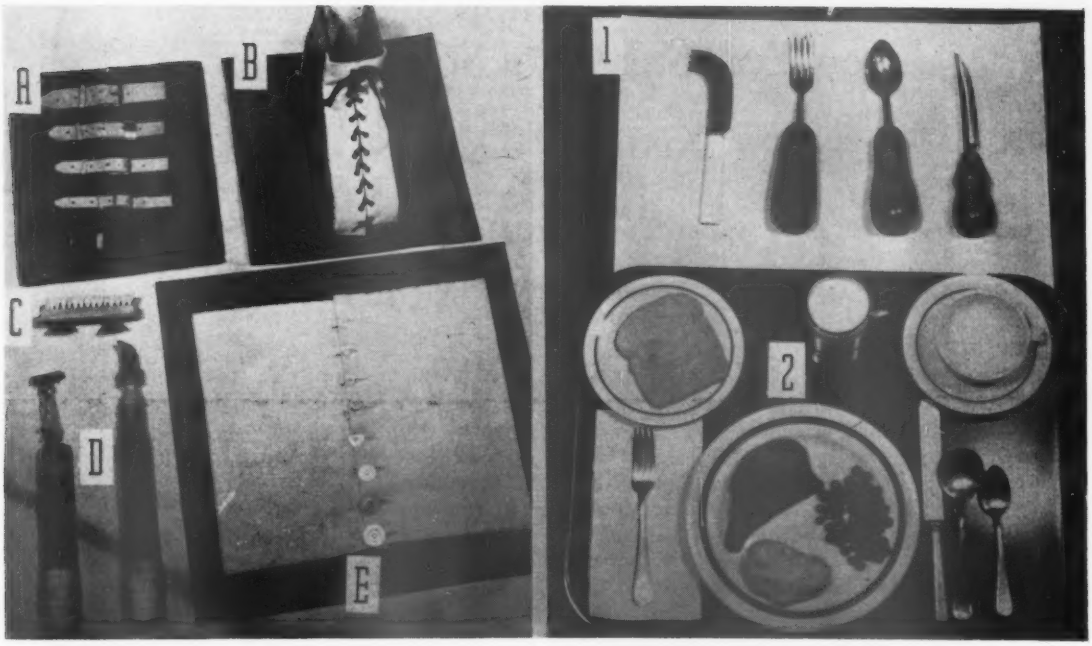
Lack of specially trained personnel is not the important thing that hinders patients from being physically rehabilitated today. The important thing is lack of interest, and indifference to the goals of self care, by all persons who serve and wait upon patients. The number of patients who can be taught to get out of bed, and even to walk, is in the majority, provided they have the motivation to help themselves again. Age, the duration and type of the disability, are not the deciding factors for any patient who has the motivation and someone to guide him in recovering physical self-sufficiency.[7]

We must "unlearn" relatives, nurses, and doctors, who want to give total selfless service to patients. Those individuals and everyone else concerned with any patient must become indoctrinated with the philosophy and possibilities of rehabilitation for the majority of so-called "helpless" individuals. This program belongs in every hospital and every nursing and convalescent home. A patient should not have to wait ten to twenty years to be physically rehabilitated when it can be started early after the onset of a sudden and acute disability and when the patient is most often in an acute general hospital.

Our advances in medicine keep far more people alive today and living to an older age than before. There are not enough beds in our hospitals, nursing, and convalescent homes now to care for all the

†Physical therapists employed by state chapters of the National Society for Crippled Children and Adults are available for consultation. Other physical therapists employed in private capacities are also available.

‡Courses are offered by the Institute of Physical Medicine and Rehabilitation, New York University-Bellevue Medical Center, and by the State of Connecticut Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm, Hospital for Chronic Illness, Rocky Hill, Connecticut.



(A) A buckle board, for practice in fastening and unfastening buckles of various sizes and styles. (B) Practice shoe, to learn to lace and tie bow with one hand. Patients graduate from this to regular shoes. (C) Ordinary scrub brush with simple suction cups to put on wall beside sink so patient can wash one hand. (D) Built up handles for razor and shaving brush to secure larger grasp as well as additional length when patient cannot get hand close to face. (E) Button board, for practice in buttoning and unbuttoning various sized buttons. (1) A combination one-handed knife and fork, and an ordinary fork, spoon, and knife with built up handles, to be used when patient cannot close fingers completely. Various shapes and sizes are easily made for the individual patient. (2) Modeling clay (colored) to represent a chop, a potato, peas, and a slice of bread. Patients practice cutting the meat and potato, buttering the bread, putting food on fork and spoon and bringing it to their mouths. A thin wire hoop is attached about the glass so that it can be lifted more easily. Such eating drills are as good in re-training the blind as for those with physical disabilities. The chop and potato are refashioned many times a day, as patients take turns at the practice.

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bed-ridden (the majority, unnecessarily so) invalids. The problems of the aging, of which we hear so much, is an acute problem now. It is not a problem just of the future. Only by rehabilitating as many physically helpless individuals as possible now, and by preventing this needless load in the future will we have beds and personnel available to care for our increasing aged population.

The achievement of physical independence is of the utmost importance in restoring an individual's self respect. If the individual can be made economically self sufficient again, the financial gains to himself and his community are tangible gains. Every individual who is physically self sufficient saves money for himself or for others. If employed, naturally the financial gains are far greater. The cost of care for one individual throughout his life expectancy totals to many thousands of dollars. The savings for each self sufficient individual, multiplied by many others, totals into millions. These savings will be needed in the future to care for the aging population. It is false economy then not to do the utmost in physical rehabilitation. Financial gains alone are measurable, but the restoration of self respect and happiness to an individual is of far more importance.

(References on page 40.)

Ten-Year Survey of Stillbirths and Neonatal Deaths

HOSPITAL OF THE WOMAN'S MEDICAL COLLEGE OF PENNSYLVANIA

Anne H. Pike, M.D.

TO OBTAIN AN ACCURATE PICTURE of infant mortality on an obstetric service, stillbirths and neonatal deaths must be discussed together. The lapse of a few minutes may determine whether a child will be born alive or dead, the same condition being the cause in either case.

During the ten-year period, January 1941, to December 1950, inclusive, there were 11,059 infants born on the maternity service at the Hospital of the Woman's Medical College of Pennsylvania. This figure includes those born on the out-practice service which was discontinued in September 1943. There were 457 (4.13 percent) infant deaths. There were 447 mothers, the infants being from single pregnancies in 430 (96.2 percent) of the cases, from twin pregnancies in 16 (3.6 percent), and from a triple pregnancy in one (0.2 percent) of the cases. Of the total infant deaths, 225 (49.2 percent) were stillbirths and 232 (50.8 percent) were neonatal deaths. Necropsy examinations were performed in 57 (25.3 percent) of the stillbirths and in 130 (56 percent) of the neonatal deaths, or in 187 (40.9 percent) of all infant deaths. (Table 1.)

Of the stillbirths, 61.8 percent were due to causes operating prior to labor, there being some 139 antepartum deaths. There were 86 (38.2 percent) intrapartum deaths. Premature infants accounted for 162 (69.8 percent) of the neonatal deaths. These figures compare favorably with those quoted in the literature which state that 4 percent (4.13 percent WMCH) of all feti and newborn children die before, during, and after delivery. Of these about one-third (30.4 percent WMCH) die in utero, one-fifth (18.8 percent WMCH) perish during births, and about one-half (50.8 percent WMCH) die in the neonatal period.

Dr. Pike is Clinical Assistant in Gynecology and Obstetrics at the Woman's Medical College of Pennsylvania. *This paper was presented at the Tri-City meeting of the Obstetrical Societies of Boston, New York, and Philadelphia, at the Hospital of the Woman's Medical College April 10, 1951.*

DEFINITIONS[1]

Live Birth—A child showing any evidence of life (action of heart, breathing, or movement of voluntary muscle) after complete birth should be registered as a live birth.

Stillbirth—A fetus showing no evidence of life after complete birth (no action of heart, breathing, or movement of voluntary muscle), if the twentieth week of gestation has been reached, should be registered as a stillbirth.

Neonatal Period—The time from birth to the end of the first month of life.

Premature Infant—The dividing line between prematurity and maturity has been established as 5½ pounds (2500 Gm.) or 37 weeks' gestation.

Infants may be classified as previable, viable, term, and post-mature, according to the three criteria of length of gestation, body length, and weight. Two of these criteria must be satisfied to place the infant in one of the above categories. The standard as set forth at Chicago Lying-In is shown in Table 2.[2] There was sufficient data obtainable to group the stillbirths in this study according to this standard, but it was not possible to do so with the neonatal deaths. These latter infants were signed out as "premature" and "term" according to the above definition, and data is based on this information.

Both private and ward patients were included in this survey. Routinely, all mothers received 4.8 mgm. of vitamin K intramuscularly on admission and every six hours during labor, and all infants received 2.4 mgm. of vitamin K intramuscularly at birth. The infants were discharged immediately to the care of a pediatrician when premature or if the delivery was complicated. All infants were placed in a heated crib, aspirated, and given oxygen, or placed

TABLE 1. TOTAL DELIVERIES* AND INFANT DEATHS

Year	Mothers	Infants			Still-births†		Neonatal Deaths		Total Infant Deaths	
	Total	Sets of Twins	Sets of Triplets	Total Infants	No.	%	No.	%	No.	%
1941	995	7		962	22	2.3	24	2.5	46	4.8
1942	1,004	8	1	1,014	21	2.1	18	1.8	39	3.8
1943	994	8		1,002	27	2.7	18	1.8	45	4.5
1944	960	13		973	20	2.1	21	2.2	41	4.2
1945	913	5		918	21	2.3	12	1.3	33	3.6
1946	1,136	9		1,145	22	1.9	24	2.1	46	4.0
1947	1,539	18		1,557	34	2.2	51	3.2	85	5.5
1948	1,180	11		1,191	21	1.8	21	1.8	42	3.5
1949	1,132	14		1,146	11	1.0	20	1.8	31	2.7
1950	1,143	8		1,151	26	2.3	23	2.0	49	4.3
Total	10,956	101	1	11,059	225	2.0	232	2.1	457	4.1

*Including out practice. †Corrected for abortions.

TABLE 2. CRITERIA FOR CLASSIFICATION AS TO PERIOD OF FETAL DEVELOPMENT CHICAGO LYING-IN HOSPITAL

	Weeks of Gestation	Crown Heel Length in mm.	Weight in Gm.
Abortion	Under 22*	Under 280	Under 400
Previable	22–28	280–349	400–999
Viable	29–38	350–469	1000–2499
Term	39–42	470–540	2500–4499
Postmature	Over 42	Over 540	Over 4500

* Woman's Medical College Hospital statistics, "Under 20 weeks."

in an incubator if necessary. They were observed in the delivery room for one hour after delivery.

No attempt is made at corrected figures except where noted; therefore, all infants with congenital defects and previable prematures are included.

Stillbirths

Causes of stillbirths are listed in Table 3. Of these there were 14 (6.2 percent) congenital anomalies. Five were intrapartum deaths; three of the hydrocephalic infants died during delivery following craniotomies, and two of the anencephalic infants died during spontaneous deliveries. Osteochondrosis and a meningocele accounted for the other two deaths in this group.

Antepartum deaths

Of the 139 antepartum deaths, cause was undetermined in 50 (36.0 percent). In 66 (47.5 percent) no cause of death was found in the fetus, but the following maternal complications were active: toxemia in 21; infarcts of placenta in two; abruptio placenta in five; strangulated cord in six; myomata in two; habitual abortion in two; grand mal seizure in one; hypertensive cardiovascular disease with decompensation in one; polyhydramnios in one; velamentous attachment of the cord in one. Thirty-one (73.8 percent) of these 42 deaths occurred prior to term. Other maternal complications were lues, 18; diabetes, one; trauma, two; post-term, two; and acute infectious encephalitis, one. Asphyxia in the infant was found at autopsy in three (2.1 percent) of the cases, two having maternal complications of diabetic coma and eclampsia, and one a true knot of the cord. Erythroblastosis was a factor in seven cases (5.0 percent); lues in the infant in four cases (2.9 percent); and congenital anomalies in nine cases (6.5 percent). Ninety-seven (69.8 percent) of the antepartum deaths occurred prior to term.

Intrapartum deaths

All deaths from cerebral hemorrhage occurred in term infants. Ten were in cases where disproportion existed as evidenced by methods of delivery: failed forceps with version and extraction, three; high axis

TABLE 3. STILLBIRTHS AND CAUSES OF DEATH

Causes of Death	Stillbirths		Stillbirths less Congenital Anomalies*	
	Number	Percent	Number	Percent
Stillbirths	225	100.0	211	93.8
Intrapartum	86	38.2	81	36.0
Cerebral hemorrhage	19	8.4	16	7.1
Cord complications	13	5.8	13	5.8
Praevia & abruptio	24	10.7	24	10.7
Asphyxia (other causes)	30	13.3	28	12.4
Antepartum	139	61.8	130	57.8

*There were 14 (6.2 percent) congenital anomalies of the total deaths in the stillbirths group.

traction forceps, five; high mid-forceps with impacted shoulders, one; mid-mid forceps, one. Abnormal presentation contributed to death in five cases: one transverse; one breech and one face presentation; and two persistent occiput posterior presentations. Craniotomy was performed on three hydrocephalic infants. Uterine inertia with a prolonged second state was a cause of intrapartum death. Prolapsed cord occurred in ten cases; four (40 percent) were in prematures. Version and extraction was performed in four cases with the initial position being transverse in three cases and longitudinal in one. Strangulation by the cord led to the death of three infants.

It is noteworthy that, of the 22 cases of abruptio placenta, 18 (81.8 percent) occurred in premature infants. Classical Cesarean section was performed in 8 (36.4 percent) of these cases.

Included under asphyxia—other causes—there were two cases of ruptured uteri followed by hysterectomy. One occurred following a previous section and the other in a multiple (triplet) pregnancy. Cause of asphyxia was undetermined in four cases; uterine inertia was given as a cause in four; precipitate labor in two; malpresentation in three; impacted shoulders in one; delay in delivery in multiple pregnancy in five; aspiration of amniotic fluid in two; and anencephalic monster in two. Of the total intrapartum deaths, 50 percent occurred in premature and 50 percent in term infants.

Neonatal Deaths

Of the 232 neonatal deaths 162 (69.8 percent) occurred in premature infants. (Table 4.) Under asphyxia — intrauterine maternal — abruptio placenta again occurred prior to term in the greatest number of cases, 12 out of 13 (90.8 percent). Placenta praevia was present in 10 cases, all below term. Pre-eclampsia was listed as the cause of death in eight cases. In this group 43 (89.6 percent) were premature infants.

TABLE 4. NEONATAL DEATHS

Neonatal Deaths Causes	Premature	Term	Total	Percent Premature	Percent Total Neonatal Deaths
Prematurity only diagnosis	75	0	75	100.0	32.3
Asphyxia pe se	10	8	18	55.6	7.8
Intrauterine—maternal	33	5	38	89.6	16.4
Extrauterine—fetal	15	3	18	83.3	7.8
Trauma of delivery	5	18	23	21.7	9.9
Erythroblastosis	.....	4	4	.....	1.7
Jaundice of newborn	1	2	3	33.3	1.3
Infections	8	2	10	72.7	4.3
Gastrointestinal disturbances	4	6	10	40.0	4.3
Undetermined	.....	1	1	.....	0.4
Congenital anomalies	11	21	32	34.4	13.8
Total	162	70	232	69.8	100.0

TABLE 5. AUTOPSY DIAGNOSES

Autopsy Diagnoses Stillbirths Neonatal Deaths	Stillbirths				Neonatal Deaths		Totals	
	Antepartum	Intrapartum	Totals Number	Totals Percent	Number	Percent	Number	Percent
Undetermined	19	5	24	42.1	.....	.....	24	12.8
Asphyxia	3	15	18	31.5	33	25.4	51	27.3
Aspirated Amniotic fluid	..	1	1	1.8	.....	.....	1	0.5
Aspirated Foreign body	..	..	.....	.....	2	1.5	2	1.1
Atelectasis	..	..	.....	.....	13	10.0	13	7.0
Intra-alveloar hemorrhage	..	..	.....	.....	2	1.5	2	1.1
Cerebral Hemorrhage	..	3	3	5.2	17	13.1	20	10.7
Congenital anomalies	3	2	5	8.8	25	19.2	30	16.0
Overdue	..	1	1	1.8	.....	.....	1	0.5
Erythroblastosis	1	..	1	1.8	4	3.1	5	2.7
Jaundice of newborn	..	..	.....	.....	3	2.3	3	1.6
Infections	..	..	.....	.....	11	8.5	15	8.0
Pneumonia	..	..	.....	.....	6	.....	6	.....
Nephritis	..	..	.....	.....	1	.....	1	.....
Meningitis	..	..	.....	.....	2	.....	2	.....
Syphilis	4	..	4	7.0	2	.....	6	.....
Gastrointestinal disturbances	..	..	.....	.....	7	5.4	7	3.7
Malnutrition, diarrhea	..	..	.....	.....	3	.....	3	.....
Intestinal obstruction	..	..	.....	.....	1	.....	1	.....
Fecal meconium peritonitis	..	..	.....	.....	1	.....	1	.....
Perforated stomach	..	..	.....	.....	1	.....	1	.....
Acute ulcerative colitis	..	..	.....	.....	1	.....	1	.....
Prematurity only diagnosis	..	..	.....	.....	13	10.0	13	7.0
Total	30	27	57	100.0	130	100.0	187	100.0

Prematurity coupled with other diagnoses, 63; total prematures, therefore, 76 (40.6%).

As a cause of extrauterine asphyxia, atelectasis occurred in 13 cases; aspiration of foreign body in three; and intra-alveolar hemorrhage in two.

As a result of trauma at delivery, cerebral hemorrhage with tentorial tear occurred in 19 cases and "birth injury" in four cases. Infections included pneumonia, meningitis, lues, and nephritis. There was one case of fecal meconium peritonitis among the gastrointestinal disturbances, which also included malnutrition and diarrhea in four; intestinal obstruction in one; peritonitis and volvulus in one; perforated stomach in one; and acute ulcerative colitis in one.

Cardiac anomalies accounted for approximately one-third of the deaths from congenital anomalies, 12 out of the 32. Eight of these infants were at term. There were six anencephalic monsters; four hydrocephalic monsters; four infants with gastrointestinal anomalies; four with genitourinary anomalies; two with respiratory anomalies; two with brain anomalies; and one with the skeletal anomaly of achondroplasia.

Neonatal deaths followed sections in 27 (11.6 percent) of the cases. Twenty-two (81.5 percent) resulted in premature infants. Indications for the sections were praevia placenta, four; abruptio placenta, seven; uterine inertia, one; toxemia, eight; polyhydramnios, one; with myomectomy, one. The indications for sections at term were disproportion, three; and previous section, two.

The foregoing classification of causes of deaths is based upon positive autopsy findings and those clinical changes in the infant resulting from maternal complications. One can run into error here if few autopsies are performed (only 40.9 percent), however, because even in the presence of specific maternal complications, necropsy may show an unrelated cause of death. Table 5 lists autopsy diag-

noses for the stillbirths and neonatal deaths. The table is self-explanatory. Prematurity cannot be considered a cause of death in a stillborn fetus. Unless some pathologic condition develops, the premature infant should be born alive, although an extrauterine existence cannot be established.

Methods of delivery as employed separate from the causes of death are listed in Table 6. It is of interest to note that of the total breech deliveries, 52 (72.2 percent) occurred in premature infants. Of the total 262 normal spontaneous deliveries, 83 (69.8 percent) were prematures. Sections were done predominately prior to term, 30 out of 39 (76.9 percent). Classical sections were performed in 38 (97.4 percent) of the cases. This ratio is reversed in the forceps deliveries, 29 of the 46 (63.0 percent) being at term and in version and extractions; 18 of the 32 (56 percent) being at term.

The use of corrected mortality statistics is justifiable only when it is necessary to evaluate the method of delivery and deaths. Here, those babies dead before the onset of labor and those grossly deformed are not included. See Table 7 for deliveries leading to intrapartum deaths, excluding antepartum deaths and congenital anomalies.

Anesthesia and analgesia

Routine analgesia was demerol 100 mgm. (with no other drug) repeated every four hours as needed. If it was hoped that premature labor could be halted; morphine sulfate gr. 1/6 was employed; otherwise, no analgesia was used in premature labors. In the stillbirth group, rectal ether was used in 18 cases in the 1941-1945 period and in two cases in the 1946-1950 period.

Anesthesia used was tabulated for the stillbirths. None was used in 73 premature deliveries and in 22 term deliveries, making a total of 42.6 percent of patients receiving no anesthesia. Nitrous oxide-oxygen-ether was used in 26.5 percent of the cases; nitrous oxide-oxygen in 11.2 percent; local—nitrous oxide-oxygen in 1.4 percent; open drop ether in 9.0 percent; ether-oxygen in 8.5 percent; cyclopropane-oxygen-ether in 0.4 percent; and spinal anesthesia in 0.4 percent. Oxygen with the nitrous oxide was always in concentration of 20 percent or more. Only

TABLE 6. MORTALITY ACCORDING TO METHOD OF DELIVERY

Method of Delivery	Total Deliveries		Still-births		Neonatal Deaths	
	Number	Percent	Number	Percent	Number	Percent
Normal Spontaneous Delivery	262	57.8	130	58.3	132	57.2
Vertex	260		130		130	
Face	2				2	
Forceps	46	10.1	28	12.6	18	7.8
Outlet	14		8		6	
Low Mid	12		7		5	
Mid Mid	9		5		4	
High Mid	3		2		1	
Axis Traction	8		6		2	
Breech	73	15.9	30	13.4	43	18.2
Spontaneous	18		10		8	
Aid	35		12		23	
Extraction	11		4		7	
with pipers	6		2		4	
with craniotomy	2		2			
Version & Extraction	32	7.1	21	9.4	11	4.8
Version & Extraction, alone	22		15		7	
with pipers	2		2			
after failed forceps	5		3		2	
with pipers	2				2	
with craniotomy	1		1			
Cesarian Section	39	8.6	13	5.4	26	11.6
Classical	34		1		23	
with myomectomy	1				1	
with sterilization	3		1		2	
Low Cervical	1		1			
Hysterectomy	2	0.5	1	0.9	1	0.4
Total	454	100.0	223*	100.0	231†	100.0

*Hysterectomy with triplets 225 minus 2=223.
†Classical section with twins 232 minus 1=231.
(All other multiple deliveries were from below and in this table are recorded as individual methods of delivery.)
Total mothers in stillbirth group 222; in neonatal death group 225.

TABLE 7. STILLBIRTHS AND METHODS OF DELIVERY

Method of Delivery	Stillbirth Deliveries			
	Number	Percent	Total less Antepartum Deaths and Congenital Anomalies	Percent Corrected Stillbirth Deliveries
Normal Spontaneous Delivery	130	58.3	24	10.7
Low Forceps	15	6.7	10	4.5
High Forceps	13	5.8	12	5.3
Breech	30	13.5	8	3.6
Version & Extraction	21	9.4	14	6.3
Cesarian Section	13	5.8	10	4.5
Hysterectomy	1	0.5	1	0.5
Total	223	100.0	79	35.4

two stillbirths were attributed in part to the anesthetic; in both cases there was prolonged use of nitrous oxide-oxygen-ether with poor relaxation in operative deliveries of version and extraction.

Asphyxia per se with no intrauterine—maternal or extrauterine—fetal causes was listed as the cause of death in 18 (7.8 percent) of the neonatal deaths. Necropsy diagnosis of asphyxia was made in 33 (25.4 percent) of the neonatal deaths. Although no data is presented, it must not be forgotten that these cases of neonatal asphyxia may have resulted from drug depression, either from the analgesic used during labor or from the anesthetic used during delivery.

Miscellaneous data

Economic status: 305 (66.7 percent) of the infant deaths occurred in ward patients. 152 (33.3 percent) were private patients. This same percentage was true in both the neonatal and stillbirth groups where 67.2 percent and 66.2 percent were ward patients.

Racial: There were 222 Negro mothers and 225 white mothers. Of the neonatal deaths, 111 (49.3 percent) were white and 114 (50.7 percent) were Negro. Of the stillbirths, 114 (51.4 percent) were white and 108 (48.6 percent) were Negro.

Parity: The death rate was higher in the para one and two in the white patient than in the Negro.

Age: Gross inspection of graphs made of the number of deaths and ages of the parents showed that more deaths occurred between the ages of 23 and 35 in the stillborn group and more between 20 and 30 in the neonatal group.

Seasonal trend was not significant, but the graph indicated a greater number of deaths between the months of May and October.

Multiparity: Of the three sets of twins, one of which was stillborn, in only one set was the other twin classified as a neonatal death. Of the five sets of twins, each having one neonatal death, only one of the others was stillborn. The other four lived.

Sex: Stillborn feti delivered early in pregnancy have been found to be more commonly male than female. In this survey there were 64.5 percent previable males, 47.7 percent viable males, making the premature infants 51.4 percent males; and of the term infants 54.1 percent were males. Of the total stillborn infants, 52.4 percent were males. In the neonatal group of the premature infants 60.6 percent were males, and of the term infants 68.6 percent were males, making a total of 62.9 percent males in this group. Of the total infant deaths, 57.8 percent were males and 42.2 percent were females.

Weeks of gestation: In the stillborn group it was possible to tabulate age of the infant according to Table 2; previable, 13.8 percent; viable, 48.4 percent; term, 36.4 percent; and post-term, 1.4 percent.

Finally, the major causes of infant deaths, (stillbirths and neonatal deaths combined), are listed in Table 8.

Discussion

When total loss of life is considered both before and after birth, anoxia, either caused by interference with the passage of fetal blood into the placenta or by failure of fetal blood to obtain oxygen from the placenta, is responsible for more deaths than any other condition. The principal pathologic state causing such a disturbance is premature detachment of the placenta [in this study there were 52 cases (23.5 percent)]. The second largest group is prematurity, and so on (see Table 8).

We have at hand means of reducing deaths from erythroblastosis, lues, and infections in general. Improved judgment and greater skill in the management of labor and delivery will cut down the number of deaths from trauma and improper use of

TABLE 8. MAJOR CAUSES OF DEATH
STILLBIRTHS AND NEONATAL DEATHS COMBINED

Causes of Death	Antepartum	Intrapartum	Neonatal	Total	Percent Total
Anoxia	45	67	74	186	40.7
Prematurity	.....	.....	75	75	16.4
Antepartum—no cause	50	.....	.....	50	10.9
Congenital anomalies	9	.....	32	41	9.0
Birth trauma	.....	19	23	42	9.2
Erythroblastosis	7	.....	4	11	2.4
Syphilis					
Infant	4	.....	2	6	1.3
Maternal	18	.....	.....	18	4.0
Other	6	.....	22	28	6.1
Total	139	86	232	457	100.0

analgesics and anesthetics. Gross cardiac anomalies are not critical until after birth. Mortality from other congenital defects also is decreasing, for not only has surgical technique improved but it has been found that infants under two to three days of age withstand surgery well.

The obstetrician must beware of more than the usual "bloody show," for complete separation of the placenta may occur before delivery and result in intrauterine asphyxia and death of the infant. The obstetrician must balance the danger to the mother's life against prematurity of the infant in deciding upon the optimum time for and the mode of delivery in praevia, abruptio, pre-eclampsia, and other maternal complications.

In two fields, our knowledge of the manner in which we may further decrease the mortality is completely lacking: fetal deaths before the onset of labor, and premature onset of labor in the absence of discernible maternal abnormalities. The macerated fetus and placenta must be studied, even though maceration makes the examination difficult. We do not know how to prevent premature labor, but we can prevent conditions necessitating induction of premature labor. Furthermore, we must not let the pediatricians lull us into a false sense of security by the increased salvage of premature infants made possible by their improved techniques for the care of the premature infant.

Summary

1. A statistical survey of the stillbirths and neonatal deaths at the Hospital of the Woman's Medical College of Pennsylvania has been presented.

2. During a ten-year period (1941-1950) 11,059 infants were delivered, with 457 (4.13 percent) infant deaths. Of these, 225 (49.2 percent) were stillbirths, and 232 (50.8 percent) were neonatal deaths.

3. Of 457 infant deaths there were 187 (40.9 percent) necropsies. Error in classification of deaths is possible here, because, even in the presence of specific maternal complications, necropsy may have shown an unrelated cause of death.

4. Diagnoses quoted are those recorded on the summary sheets of the hospital charts.

5. Definitions and the basis for classifications are outlined.

6. The use of corrected statistics is used sparingly, for it is justifiable only when it is necessary to evaluate and that was not within the scope of this report.

7. Anoxia and prematurity were the major causes of infant deaths. They were the cause in 45.5 percent and 16.4 percent of the cases, respectively. It must be remembered that prematurity cannot be considered a cause of death in a stillborn fetus.

References

[1]Potter, Edith L., and Adair, Fred L., Fetal and neonatal death, pg. 10, University of Chicago Press, Chicago, 1949.

[2]McCormick, Charles O., Textbook on pathology of labor, the puerperium and the newborn, pp. 379-380, C. V. Mosby Co., St. Louis, 1944.

MODERN CONCEPTS OF PHYSIOLOGY

Fluid Therapy

Esther M. Greisheimer, M.D.

IN ORDER TO PRESCRIBE the correct fluid therapy for any individual patient, it is desirable to take into account not only the fundamental principles of water and electrolyte metabolism but also those of acid-base equilibrium, since a disturbance in one seems to lead, without fail, to a disturbance in the other. The compensatory reactions which occur are concerned in bringing about adjustments to both types of disturbances. Darrow[1] has emphasized the frequency of such disorders by stating that they may develop in almost any disease, at any age, as well as in surgical practice.

The importance of water is indicated by the fact that it constitutes about 70 percent of the body weight. Gamble[2] divides body water into two main fluid compartments; these are, first, intracellular water, which amounts to about 50 percent of the body weight; and second, extracellular water, which amounts to about 20 percent of the body weight. The latter may be subdivided into the vascular portion or plasma and the interstitial portion, which includes tissue fluid, lymph, fluid in serous cavities and in chambers of the eye, and cerebrospinal fluid. The plasma composes about 4.5 to 5 percent, and the interstitial fluid about 14.5 or 15.0 percent of the body weight. The amount of total body water can be determined in the living body by the use of heavy water or deuterium oxide. The amount of extracellular fluid is determined by the use of various substances, of which thiocyanate is most commonly used, although inulin is thought to give a more accurate estimate. Plasma volume is determined by the use of Evans blue dye or T-1824. The difference between the thiocyanate or inulin space and plasma volume is a measure of the interstitial fluid volume. Total blood volume may be estimated by combined measurements with carbon monoxide and dye, with radioactive iron (tagged cells) and dye, and with radioactive phosphorus and T-1824.

Water moves readily from one compartment to another under the influence of various factors. One of these factors is hydrostatic pressure. This factor is especially important in the passage of water from plasma to tissue fluid across the capillary wall. At the arterial end of a vascular capillary the hydrostatic pressure is great enough to overcome opposing factors and filter water across the permeable wall into the tissue fluid.

A second factor is colloid osmotic pressure or the osmotic pressure due to plasma proteins. It is the effective osmotic pressure of the plasma proteins which is responsible for pulling in water at the venous end of the capillary, since here it overbalances the filtering force of the lowered hydrostatic pressure of the blood. Consequently, tissue fluid is formed by filtration at the arterial end of vascular capillaries, but, in order to maintain plasma volume, some of the filtrate must be pulled back in at the venous end of the capillary. This is called Starling's hypothesis; it has been accepted by most physiologists as the correct explanation for the passage of fluid out of and back into vascular capillaries. However, in view of the arrangement and function of the various structures in the capillary bed as described by Chambers,[3] it is now thought that outward filtration may take place in thoroughfare channels and inward filtration in true capillaries. Regardless of the explanation of the escape of fluid from the vascular capillaries, the course traversed by this fluid may differ from time to time. Instead of re-entering vascular capillaries, the filtered fluid may remain in the interstitial fluid reservoir; it may enter the cells and become part of the intracellular fluid; or it may enter the lymphatic system, traverse this, and eventually re-enter the vascular system.

A third factor concerned in the movement of water from one compartment to another is the concentration of electrolytes; this refers to the concen-

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tration of osmotically active electrolytes which are held on one side or the other of the cell membrane. This factor becomes especially important under abnormal conditions.

All the dissolved constituents of the plasma, except the proteins, can pass readily through the capillary wall in either direction. As a result, electrolytes, glucose, urea, etc., are found in approximately equal concentrations (with minor differences depending on Donnan equilibrium) throughout the extracellular compartment. The chief difference in composition between blood plasma and tissue fluid is the higher concentration of protein in the former. In certain regions of the body the capillaries of the vascular system are readily permeable to protein (liver and intestine), and the lymph from these areas contains almost as much protein as the plasma. According to Drinker[4] an important function of the lymphatic system is to transport newly formed protein from the liver, together with that which has escaped through peripheral vascular capillaries, to the vascular system.

The approximate composition of plasma and striated muscle (representing the intracellular compartment) is given in the accompanying table.

COMPOSITION OF PLASMA AND STRIATED MUSCLE

(In milliequivalents per liter)

	Plasma	Muscle
Na	142	23-35
K	5	115
Ca	5	—
Mg	3	45
HCO_3	27	10
Cl	103	—
HPO_4	2	100
SO_4	1	20
Organic acids	6	—
Protein	16	75

It is evident that sodium is the most abundant cation, and chloride the most abundant anion in plasma (and tissue fluid). The extracellular fluid provides a constant environment for the cells and is the path of exchange for a great variety of substances which pass between the outer environment and the cells.

The properties of the cell membrane differ from those of the capillary wall; consequently, it forms a different type of barrier. Although water can enter and leave cells freely, electrolytes pass with more difficulty and are not freely diffusible with those of the extracellular phase. Potassium is the most abundant intracellular cation, and phosphate and protein are the most abundant intracellular anions. There is some sodium inside skeletal and cardiac muscle cells; the intracellular sodium is almost equivalent to the total extracellular bicarbonate, or equal to about one-sixth of the total extracellular sodium.[1] There is some intracellular chloride, as this anion is present in the cells of the gastric mucosa, erythrocytes, tendons, and testes. The total osmolar concentrations are equal in both the extracellular and intracellular compartments. The intracellular fluid forms a suitable medium for the processes of cellular metabolism.

The functions of some of the abundant constituents of the fluid compartments will be listed. Water is the medium of transport of food, waste, hormones, vitamins, etc. It is important as a solvent. It makes possible the distribution of heat from deeper to superficial structures, and, because of its latent heat of evaporation, plays an essential part in the regulation of body temperature. Sodium maintains osmotic pressure and thus preserves isotonicity with the intracellular fluid. It is an important base; no other cation can replace it in its role in the maintenance of pH. It contributes to excitability and contractility of muscles. Potassium plays a role in conduction of nerve impulses and in contractility of muscles.

Acid-base equilibrium

The reaction of body fluids and tissues is maintained just on the alkaline side of neutrality. Since acids are being formed constantly in metabolism (carbonic, organic acids, sulphuric, phosphoric) there is need for neutralization of them. The presence of buffer acids and their salts makes possible the regulation of the acid-base relationship in a satisfactory manner. This depends upon the fact that the hydrogen ion concentration of a solution, such as plasma, which contains a buffer acid and its salt, varies directly with the ratio of the acid to the salt. The buffers which are available for neutralizing acids produced by metabolism are $HHCO_3/BHCO_3$, BH_2PO_4/B_2HPO_4, and the proteins of plasma and erythrocytes (hemoglobin). The first is undoubtedly the most important in the maintenance of alkalinity of body fluids. The ratio of $HHCO_3/BHCO_3$ is normally 1/20. When acid is added, the numerator increases, which increases the ratio. This means an increase in the tension of carbon dioxide in arterial blood, which, in turn, stimulates respiration, and excess carbon dioxide is blown off, its tension reduced, and the ratio restored to normal.

On the contrary, when base accumulates, the denominator increases, which decreases the ratio. This means a decrease in tension of carbon dioxide in arterial blood. When this occurs, respiration is depressed and carbon dioxide retained, with a restoration of the ratio to normal.

In addition to the above adjustments by respiration, the kidneys aid in regulation of the acid-base equilibrium. Sodium and chloride are reabsorbed in proximal tubules under the influence of the adrenal cortical hormones. In distal tubules disodium phosphate is changed to monosodium phosphate, and sodium is absorbed. In addition, ammonia is formed and combined with many acid molecules for excretion, thus saving sodium. An additional mechanism consists in the ability of the kidneys to excrete sodium bicarbonate if there is an excess of sodium in the body, or to excrete free organic acids when the need to conserve base is urgent.

Water balance

In order to prevent dehydration or edema, water intake and output must be equal. The intake of water includes 1000 to 1200 cc. taken as beverage, 1000 cc. in food, and 300 to 350 cc. produced daily in the cells by the oxidative processes of metabolism. The output includes water lost by evaporation, in urine, and in feces. The loss by evaporation includes the insensible loss of 500 cc. from the skin and 350 to 500 cc. by the lungs. On the average, 44 Gm. of water are lost for each 100 Cal. of metabolism. The loss by urine may be equal to 1500 cc., and by feces, 150 to 200 cc. daily. The insensible cutaneous loss depends on the surface area, metabolic rate, and body temperature. If the need to regulate body temperature requires it, there may be a sensible loss or perspiration, in addition to the insensible loss, from the skin. The amount lost by perspiration is variable. The loss by way of urine depends on the concentrating power of the kidneys and the amount of waste products to be excreted. The renal concentrating power may be diminished in many conditions.

The concentration of electrolytes in the plasma plays a part in the maintenance of water balance, in an indirect manner. There are receptors, called osmoreceptors, in the supraoptic nuclei of the hypothalamus; these are sensitive to the concentration of electrolytes in the blood bathing them. If the concentration of electrolytes increases, the osmoreceptors respond by sending impulses to the posterior lobe of the pituitary gland to increase the output of the antidiuretic hormone. This hormone controls the reabsorption of water in the distal tubules of the kidney. Thus, when the concentration of electrolytes in the plasma increases, more water is reabsorbed from the filtrate in the lumen of the distal tubules to dilute the electrolytes and restore osmotic pressure to normal. If the concentration of electrolytes in the plasma falls, the reverse occurs. It has been found that between 10 and 20 percent of the total water reabsorbed by the renal tubules can be varied, and this is accomplished by the distal tubules, under the influence of the antidiuretic hormone of the posterior lobe of the pituitary. The water which is absorbed from the lumen of the proximal tubules is not directly under hormonal influence; it is controlled by the reabsorption of electrolytes and is obligatory.

If all intake of water should stop, it would continue to be lost by three channels. These are the evaporative loss through the skin (insensible), evaporative loss through the lungs, and a minimal urinary volume due to excretion of the products of metabolism. By means of the above, the body would lose water at a rate of about 2 percent of the body weight per day. There would be an additional loss if perspiration occurred. The obligatory loss in infants is about twice as great as in adults; if there is no intake, infants lose about 4 percent of the body weight, in terms of water, per day. This is due to the higher metabolic rate of infants.

Electrolyte balance

There must likewise be a balance between intake and output of electrolytes. Electrolytes are taken in in foods and as condiments, in some cases, and are lost in the urine, feces, and perspiration. About 8 to 15 Gm. of sodium chloride are taken in daily, and any surplus is excreted in the urine. The chloride and bicarbonate content of plasma gives an approximate measure of the changes in the total electrolyte concentration in body fluids. It is more difficult to determine the electrolyte concentration of the intracellular than of the extracellular compartment. Levitt[5] has determined the intracellular cation concentration in normal dogs by the use of radioactive isotopes. In patients, such concentrations are determined indirectly by retention shown by metabolic balance studies in the course of treatment of various abnormalities of fluid and electrolyte balance.

Abnormal conditions

It seems inevitable that if there is a loss of water, a loss of electrolyte follows, sooner or later, and vice versa. Consequently, an uncomplicated loss of water or of electrolyte cannot be of long duration. However, three types of abnormalities may exist, according to Marriott.[6] These are: (1) loss of water in excess of salt; (2) loss of salt in excess of water; and (3) mixed salt and water depletion. Each will be considered.

(To be concluded in February, 1952.)

World Health Organization

INTERNATIONAL HEALTH

THE AMERICAN PUBLIC HEALTH ASSOCIATION at its annual meeting in San Francisco, devoted an evening session to the subject, International Health. The meeting was held at the War Memorial Opera House, on October 31, with more than 2,500 persons present. The speakers were: Dr. E. A. Winslow, Editor of the *American Journal of Public Health;* Dr. Brock Chisholm, Director-General of the World Health Organization; Dr. Fred L. Soper, Regional Director of the World Health Organization for the Americas and Director of the Pan American Sanitary Bureau; Dr. Chandra Mani, Director of the WHO Regional Office for Southeast Asia; Dr. Henry Van Zile Hyde, Director of the Health and Sanitation Division of the Institute of Inter-American Affairs and the United States designated member to the WHO Executive Board, and Dr. Frank G. Boudreau, Executive Director, Milbank Memorial Fund.

Dr. Winslow, who presided at the meeting, outlined the history of previous international health organizations and the work of WHO. In closing his speech, he said: "I had the rare privilege last spring of spending two months at Geneva as a special consultant to WHO, and the job involved primarily the securing of advice and assistance in the shaping of a report which I had been invited to prepare. I spent hours in conference with almost every outstanding member of the Advisory Service and Technical Service staffs. Never in my life have I come in contact with such an able group of experts in the various technical specialties of public health. Never have I seen men and women in any organization so well knit together, so wholly cooperative, so dedicated to a common task. In the days of the League, I heard the comment that 'There is more true religion in the secretariat of the League of Nations than in all the churches of Geneva.' That goes for the WHO secretariat today."

Dr. Chisholm, speaking of the great responsibility which the nations of the world had given to WHO, said: "The very vastness of the field and the multiplicity of approaches indicate the complexity of the problems facing WHO. These are not only technical problems but also social and political. Merely to import technical equipment and knowledge into less developed countries from more developed ones may seem very simple, but that is only one small aspect of the total job. Certain conditions tend to prevent effective transplantation of health techniques, such conditions as unstable government, obsolete land tenure systems, nepotism, insecurity of tenure of civil servants, political appointments to technical positions, ignorance, sacred cows of many colors, shapes, and sizes, and under many names, poverty, low productivity, graft and corruption, irresponsibility in using international relationships for internal political purposes, excessive nationalism, excessive birth rates, and extensive misrepresentation of facts and of motives."

Dr. Chisholm added, "There is no country that I know of which is entirely free of all these problems —and *these* are the main problems in all international work, including international health."

Speaking of the problems of food supply and living space he stated that "Some governments are beginning to recognize their greatest danger in their own birth rates; others still refuse to face this uncomfortable reality. For instance, a simple choice faces the government of India: effective birth control measures immediately, or mass starvation and death for millions. Will anyone dare to suggest that India should *choose* death?" Dr. Chisholm added: "We must learn to understand peoples struggling with their own destiny, and understanding does not imply agreement with attitudes that are historically inevitable at particular stages of social development."

Dr. Mani and Dr. Soper spoke of the work being done in the Americas and Southeast Asia. Dr. Hyde gave the story of the bilateral international health programs of the United States government. "In carrying out its bilateral programs," Dr. Hyde said, "the United States looks constantly to the World Health Organization for leadership and guidance. It recognizes fully the coordinating authority given to WHO in its constitution, to which the United States is a party."

Dr. Boudreau pointed out what the world could gain by proper international cooperation through WHO. "Better health throughout the world is well worth working for, but the experience gained by working together may prove in the long run to be of far greater value," he said. "World government must be built brick by brick, beginning in areas of common interest where cooperation is possible and the results are of benefit to all."

"The World Health Organization," Dr. Boudreau declared, "is peculiarly fitted to become the spearhead of a world revolution which will have as its aim not the destruction of present civilization but the organization of a peaceful world, not the leveling down of all countries to lower standards of living, but the raising up of the poorer countries to the standards of the most healthy and prosperous. This is within our grasp; we have the ability and the means to do it, only the will falters, only the imagination fails."

Dr. Boudreau concluded his speech with this announcement: "I cannot imagine anything more inspiring than the opportunity which is open to us, to lead the way in this pioneering adventure. It therefore gives me the very greatest satisfaction to be able to announce to you that the National Health Council has decided to organize a citizens' committee for the World Health Organization. It will be the task of this committee to make known to all our people the work and potentialities of world health. It will educate and organize public opinion, so that our political leaders need never be in doubt about the people's support of WHO and all other UN agencies concerned with physical and mental health. We who pride ourselves on our skill in using the tool of health education will find this task worthy of our best efforts. It will give new zest to our work, new interest to our lives. It will fit us better to become useful members of a united world society."

The full text of these papers will appear in a forthcoming issue of the *Journal of the American Public Health Association.*

EUROPEAN LEAGUE FOR MENTAL HYGIENE

The European League for Mental Hygiene met at Vevey, Switzerland, from August 31 to September 3. Delegates from 13 nations were present, and after discussing problems of mental health in Europe the following resolutions were passed:

A. The Assembly of the European League for Mental Hygiene, having heard and discussed the reports of the delegates from 13 nations, is of the opinion that education in the principles and application of mental hygiene should be as widespread as possible, and, in the first place, should be addressed to special groups including the medical profession, educationists, nurses, psychologists, social workers, the clergy, public health officials, magistrates, and judges.

B. The Assembly is further of the opinion that, in accordance with the evidence obtained from all the delegates, the following services have proved to be the most efficacious in preventing nervous and mental disorders and character deviations, and should be instituted universally and developed as extensively as possible: guidance and advice for those about to marry, and for expectant mothers; child guidance clinics, which should also be associated with the educational services; clinical and advisory facilities for adults in the field of mental health.

Reported by Doris Odlum, M.D., London

WITH THE AMWA AROUND THE WORLD

THE A. W. H. IN THE PHILIPPINE ISLANDS

THE COOPERATIVE SERVICE undertaken by the American Women's Hospitals in conjunction with the Philippine Medical Women's Association is one of the most promising projects in which this Committee has ever been engaged. The Philippine doctors are enthusiastic in their work and manifestly inspired by their connection with the medical women of the world, especially those of the United States, the country with which the Philippine Islands has been closely associated for over fifty years.

A recent letter received from the Philippine Medical Women's Association, signed by the President, Dr. Fe del Mundo, and eight of her officers, acknowledged the receipt of $1,000 worth of medical supplies and also the subsidy provided by the American Women's Hospitals. In this letter the following paragraph appears:

"The members of the Board of Directors of the Philippine Medical Women's Association wish to acknowledge receipt of the medicines and supplies you have so graciously sent us. We also wish to thank you for your help and to assure you and the many friends there that have been giving us aid that you will not have any cause for regret in so doing. We will not disappoint you."

Enclosed was a news clipping from *The Philippine Free Press* with a photograph of the Committee of the Philippine Medical Women's Association opening the boxes of supplies.

In helping this group of young women doctors in the Philippine Islands, the American Women's Hospitals Committee is certainly fulfilling one of the fundamental objectives of the American Medical Women's Association.

American Medical Women's Association

MESSAGE FROM THE PRESIDENT

THE MID-YEAR BOARD MEETING of the American Medical Women's Association was held November 10 to 11 at the Battery Park Hotel, Asheville, North Carolina. Fifty-eight members registered from fifteen states and the District of Columbia. Dr. Irma Henderson-Smathers, Corresponding Secretary, resigned prior to the meeting, due to illness. The other officers, with the exception of the Treasurer and Assistant Treasurer, were present. Five regional directors attended. The Editor of the JOURNAL, Dr. Ada Chree Reid, who is also President of the Medical Women's International Association, and Dr. Margaret M. Wurts, Corresponding Secretary to the International Association, were present.

Reports of the regional directors and branches were made at a luncheon on the first day of the meeting. Dr. Camille Mermod, Vice-President, in charge of Organization and Membership, presided.

At the dinner meeting, Catherine Sims, Ph.D., spoke on "What the United Nations Means to a Physician." Dr. Sims is Associate Professor of History at Agnes Scott College, and gave a clear presentation of the problems confronting the United Nations.

The luncheon on the last day was devoted to the medical women of the Western North Carolina Branch. Dr. Emma S. Fink, of Crossnore, North Carolina, spoke on "A Medical Practice in the Southern Mountains." Dr. Fink told of the difficulties which make life hard but interesting in her community. She was modest, indeed, about the medical and educational contributions of her family.

An attempt was made to shorten the general business sessions so that more time was available for committee meetings. These were held at breakfast and in every free moment. Among younger members there was a feeling that the Association should become more active. Its opportunities for growth and service are almost limitless.

Dr. Lucille Marsh, of Atlanta, was elected Corresponding Secretary. Telegrams of congratulation were sent to Dr. Catharine Macfarlane, Dr. Florence Sabin, and Dr. Elise L'Esperance, who have recently received the Lasker Award. Flowers and greetings were sent to Dr. Bertha Van Hoosen, who is ill, and to Dr. Henderson-Smathers.

After the meeting was adjourned, the medical women of Asheville arranged a sightseeing trip through Biltmore House, and entertained at cocktails and a delightful buffet supper at the Biltmore Country Club. The success of the meeting resulted in large part from the efficient handling of arrangements by the local committee, of which Dr. S. Weizenblatt was chairman.

For the next meeting, the annual one in June, it is not too early to send in your suggestions. Tell us about the type of program you would enjoy and whom you would like to have speak. Most of all, tell us what you think the Association can do to increase its scope and usefulness to medical women.

Amey Chappell

AMEY CHAPPELL, M.D.

These Were The First

Dr. Eva Harding was the first woman to be nominated for Congress in a direct primary by one of the major political parties. Running on the Democratic ticket, she defeated the Reverend Herbert Corwine of Topeka, Kansas, in the First Congressional District, in 1916.

Dr. Mary Sutton Macy was the first woman physician appointed on the staff of the Children's Hospital and Schools, Randall's Island, New York, in 1917. Dr. Macy was a prominent neurologist who worked with mentally defective children.

Dr. Amelia Chopitea, the first Bolivian woman to attain the degree of Medicine and Surgery, was awarded this degree at Sucre, Bolivia, in 1927.

Dr. Rebecca Parrish was the first woman physician to practice in the Philippine Islands. She graduated in 1901 from the Indiana Medical College, and practiced for 26 years in the Philippines, where she founded the Mary Johnston Hospital in Manila. For her work in the Philippine Islands, she was awarded, in 1950, the Presidential Medal for Merit.

Dr. Thelma S. Miner, graduate, in 1944, of the University of Alberta, Canada, was the first woman appointed Medical Health Officer to Saskatchewan's regional health service.

Dr. Mary Goorwich of Russia was the first woman intern (in 1922) in Touro Infirmary, New Orleans. She received her medical degree from Tulane University of Louisiana School of Medicine.

Dr. Daisy Emery Allen is said to have been the first woman to graduate from a Texas medical school. Dr. Allen, a pediatrician, graduated in 1897 from the Fort Worth University Medical Department, M.D., cum laude. She later became Professor of Pediatrics and Embryology at Dallas Medical College, and Clinical Professor of Pediatrics at Christian University Medical Department.

Dr. Sue H. Thompson, of Hudson, New York, was the first woman county health officer to be commissioned in New York State. Dr. Thompson received her appointment in 1905.

Dr. Frances Upham, of New Jersey, graduate of Woman's Medical College of Pennsylvania in 1903, was the first woman to be appointed to the staff of Monmouth Memorial Hospital, Long Island. She specialized in eye, ear, nose, and throat.

Dr. Consuelo Vadillo, of Yucatan, graduate of the University of Medica, Yucatan, in 1931, was the first woman to receive a degree in medicine from that institution.

Dr. Helen M. M. Mackay was elected to membership as a Fellow of the Royal College of Physicians in London, 1935, the first time in the four hundred years of its history that a woman had been admitted to that body. She was associated with Queen's Hospital and was especially interested in the anemids of childhood.

Dr. Rachel Yarros was made head of the Department of Social Hygiene at the University of Illinois College of Medicine (in 1935), the first woman in the world to hold such a position.

Dr. Esther Kim Pak, graduate of Woman's Medical College of Baltimore in 1900, was the first Korean woman to become a physician. She returned to Korea where, in 1928, the first medical college for women was opened in Seoul.

Dr. Josephine Walter, who died at the age of 85 years in 1935, was the first woman intern at Mount Sinai Hospital in the City of New York. At the time of her death she was Consultant Physician at Montefiore Hospital.

Dr. Elizabeth D. Cohen, graduate of Pennsylvania Medical University in 1857, was the first woman physician to practice in New Orleans. She died (in 1921) at the age of 101.

Dr. Elizabeth M. Mosher, Honorary President of the Medical Women's National Association (now the American Medical Women's Association) from its inception in 1915 until her death in 1928, was the first physician of the Massachusetts Reformatory Prison for Women (1879). She was a graduate of the University of Michigan (1875), to which institution she was appointed Dean of Women in 1902. A noted surgeon, Dr. Mosher, in 1925, celebrated 50 years of active practice, and was then regarded as the dean of American medical women.

Dr. Emeline M. Stuart was the first English medical woman in Persia, where she was sent by the Church Missionary Society in 1897. She spent 25 years in Ispahan before going to Shiraz.

Dr. Mary O'Malley, graduate of the University of Buffalo (1897), was appointed to St. Elizabeth's Hospital, Washington, D.C., in 1905, and some years later was made Clinical Director of Women's Service in that institution. Her appointment was the first made by the United States government of a woman physician to such a high position. Dr. O'Malley was noted as an able writer and teacher, and was outstanding in research work.

Elizabeth Bass, M.D.

Medical Women's International Association

ASSOCIATION INTERNATIONALE DES FEMMES MÉDECINS

President: Dr. Ada Chree Reid
118, Riverside Drive, New York
Past President: Prof. Ch. Ruys
Vice-Presidents:

Dr. Casassa
Dr. Cuthbert
Dr. Eriksson-Lihr
Dr. Haldorsen
Dr. Montreuil-Straus
Dr. Odlum

Hon. Treasurer: Dr. Odier-Dollfus, 6, Rue de l'Alboni, Paris XVIe
Hon. Secretary: Dr. Janet Aitken, 30a, Acacia Road, London, N.W.8.

A LETTER FROM THE PRESIDENT

There is always something stimulating about the birth of a New Year! It is a time when optimism prevails and hopes are high and good resolutions are in abundance. The New Year is a time also to review the past and to plan for the future. The purpose of this letter, which we hope to send quarterly (our good resolution number one), is to keep you informed of past events and of forthcoming activities of the M.W.I.A.

Your Executive Committee met in London in July, and eight of the ten members were present. The invitation of the French Medical Women's Association to hold the 1952 Council Meeting in France was accepted and Vichy, the famous watering place, has been chosen for the meeting on September 14 and 15. The other invitation, from Austria, was declined with sincere regrets. It was decided that delegates also might attend this meeting and participate in the social and scientific programs. A registration fee will be charged to defray the cost of these affairs. One session will be devoted to scientific papers presented by some of the outstanding women doctors of France; abstracts in English will be available to those who wish them. There will also be a nonscientific session at which progress reports of M.W.I.A. activities will be made.

In accordance with action taken by the Assembly at the Sixth Congress in Philadelphia, September 1950, your Executive Committee approved the application for affiliation of the Western German Medical Women's Association. You will recall that the Assembly voted to follow the action taken by the World Medical Association and they, in May 1951, elected the Western German and Japanese Medical Associations to membership in the international organization.

At the 1952 meeting, the Council will decide upon the time and place of the 1954 Congress. To date, invitations have been received from Italy and from Australia. It would be helpful to the Council if you would let your N.C.S. know whether you will be able to attend, and your preference. While Australia seems far away to many of us, we must not fail to remember that we have many members in that part of the world. Meanwhile, invitations from other countries may be received before the Council meets—but, in any event, we would like to have your ideas.

For the members who will come from the U.S.A. to the Council Meeting, plans are being made for an all-inclusive trip including a two weeks' tour preceding the meeting; tentative arrangements include Germany and a trip up the Rhine, Switzerland, France, and perhaps Italy, if time permits. The trip is being organized by the Business Manager of the Journal of the American Medical Women's Association in conjunction with the American Express Company. Visits of medical as well as of travel interest are being planned. If you would like to join the tour, let us know. The more, the merrier!

In our next letter we will have more definite details for the 1952 meeting—but meanwhile, reserve September!

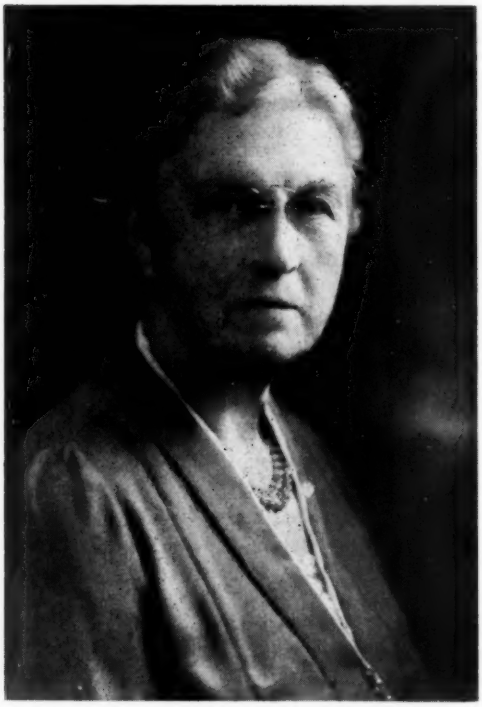
Cordial greetings for the New Year from your President,

Ada Chree Reid

Ada Chree Reid, M.D.

ALBUM OF WOMEN IN MEDICINE

MATHILDA K. WALLIN, M.D.



MATHILDA K. WALLIN is one of a distinguished group of foreign-born American women doctors, including Emily Blackwell, Marie Zakrzewska, Myra K. Merrick, Mary Putnam Jacobi (born in England of American parents), and Anna Howard Shaw, the great suffrage leader. In the early years of her work in New York, Dr. Wallin was personally associated with several of the eminent pioneers among women in medicine.

Daughter of Erik and Marie (Hanson) Wallin, Dr. Wallin was born in Upland, Sweden, on July 4, 1858. She was educated by private tutors and in public schools and graduated from the Royal Gymnastic Central Institute in 1884. The following year she went to Norway and studied in Dr. Tidemand's Orthopedic Institute.

In 1888 she came to America and spent two years in St. Paul, after which she became an instructor in gymnastics in Goucher College, Baltimore. In 1890 she entered the Woman's Medical College of the New York Infirmary for Women and Children, from which she received an M.D. degree in 1893. In accordance with the custom followed by so many American doctors at that period she went to Europe for postgraduate work, studying in Berlin.

Upon returning to the United States she developed an active practice and served at the New York Orthopedic Hospital and as orthopedic surgeon at the New York Infirmary for Women and Children. She has written for numerous medical publications and lectured before medical societies.

After the Spanish-American War in 1898, she took charge of a private hospital for convalescent soldiers on Long Island, the only woman doctor holding such a position at that time.

At the Annual Meeting of the American Medical Women's Association in June, 1917 (two months after the United States entered the First World War), a War Service Committee, subsequently known as the American Women's Hospitals Committee, was created for the purpose of participating in medical work connected with the war. Dr. Wallin was a member of this Committee from the beginning and treasurer of the Campaign Executive Committee which raised the first funds to establish this important work. In 1924 she became treasurer of the Executive Board and served until 1941, a total of 24 years.

The members of the Board of the American Women's Hospitals serving with Dr. Wallin deeply appreciated her unfailing support and devotion over a long period of years during which work was carried on in European and Asian countries, and also in the Southern highlands of the United States. In recognition of the AWH service conducted in France she received the Medaille de Reconnaissance Francaise from the French Government.

ESTHER P. LOVEJOY, M.D.

At a recent meeting of the American Medical Women's Association tribute was paid to Dr. Mathilda K. Wallin for her long and valuable service on the American Women's Hospitals Committee. A resolution of appreciation and remembrance was adopted by the assembly and delivered to Dr. Wallin on her 93rd birthday—the Fourth of July, 1951.

SIX PAST PRESIDENTS OF A.M.W.A. MEET AT HOME OF DR. WALLIN IN JUNE 1940. Dr. Wallin, at head of table, left foreground; then moving clockwise, Dr. Bertha Van Hoosen, first president; Dr. Tipton, Mullins, member of A.W.H. Board; Dr. Elizabeth Mason Hohl, twenty-fourth president; Mrs. Estelle Fraade, secretary; Dr. Helen I. Walbridge and Dr. Harriet F. Coffin, members of A.W.H. Board; Dr. Esther P. Lovejoy, sixteenth president and chairman of A.W.H. Board; Dr. Inez A. Bentley, treasurer of A.W.H. Board; Dr. Catharine Macfarlane, twentieth president; Dr. Nelle S. Noble, twenty-third president; and Dr. Mabel M. Akin, twenty-first president.

News of Women in Medicine

DR. RUTH BAKWIN and DR. SOPHIA ROBISON of New York have been elected to the executive committee of the League to Help Mentally Ill Children.

Community factors affecting the mental health of workers in a defense "boom town" will be studied by DR. MARIE JAHODA of New York University as one of the 24 new mental health research projects for which grants have been awarded by the Federal Public Health Service. Dr. Jahoda will concentrate on the effect of overcrowded living quarters and lack of health, recreation, and education facilities in a defense community.

At the State University of Iowa School of Medicine, Iowa City, Iowa, DR. MARGARET VANCE has been appointed a fellow in metabolism.

DR. MARY B. OLNEY has been promoted to Clinical Professor of Pediatrics at the University of California School of Medicine, San Francisco.

DR. FLANDERS DUNBAR of New York discussed "Personalities of Potential Centenarians" at the second annual scientific assembly of the American Academy of General Practice, Nassau County Chapter, New York.

DR. JANET T. TOWNE, Assistant Clinical Professor of Obstetrics and Gynecology, Stritch School of Medicine, Loyola University, Chicago, was one of the guest instructors at a course in the diagnosis and treatment of gynecologic cancer, which was given at the University of Kansas Medical Center, Kansas City, Kansas.

DR. ADA CHREE REID of New York, Editor of the JOURNAL, has been appointed to the advisory committee of the American Medical Writers' Association.

DR. MARCELLE BERNARD of New York recently spoke over radio station WBNX. Her topic was "Hypertension." She spoke under the auspices of the Bronx County Medical Society and the Bronx Tuberculosis and Health Association.

DR. EDITH L. POTTER, Associate Professor of Pathology at the University of Chicago was one of the visiting lecturers at an obstetric seminar sponsored by the Medical College of Georgia and the bureaus of maternal and child health of the South Carolina, Georgia, Florida state health departments.

DR. FRANCES BAKER of Burlingame, California, has been elected Secretary of the American Congress of Physical Medicine.

DR. IRENE GARROW is Chairman of the Scientific Exhibit Committee of the Medical Society of the County of Queens (New York).

Medals were presented to 15 distinguished alumni of the University of Minnesota College of Medical Sciences on October 8. Among the alumni so honored was DR. EDITH L. POTTER of Chicago, Illinois.

The clinical session of the American Medical Association was held in Los Angeles, California, December 4 to 7. DR. DOROTHY JEAN LYONS was chairman of the subcommittee on women physicians, and was assisted by DR. ELIZABETH MASON HOHL and DR. MARGARET ANN STORKAN . . . Among several color television programs was one showing a diabetic clinic. DR. HELEN MARTIN, Associate Professor of Medicine at the University of Southern California Medical School, was coordinator of this session . . . DR. MARY

M. Crosby, Research Assistant in Medicine at the University of Southern California Medical School, participated in a demonstration on cardiac catheterization . . . Another feature of this clinical session was a question and answer conference on obesity, nutrition, and health. Dr. Agnes Fay Morgan of San Francisco, California, presented "Recent Advances in Nutrition," and Dr. Ida Jean Kain of Washington, D.C. discussed "Reducing your Husband: Something Special for the Doctors' Wives."

Scientific exhibits at the clinical session included "Weight Control: An Experiment in Group Therapy," presented by Dr. Arnold B. Kurlander, Dr. Marjorie Grant, and Dr. A. L. Chapman of the United States Public Health Service, Washington, D.C. . . . Dr. Ella Roberts of the Children's Heart Hospital in Philadelphia, Pennsylvania, had an exhibit on "Oral Penicillin and Sulfonamides in the Prophylaxis of Rheumatic Fever" in which dosage, drug types, and toxicity were considered . . . "Advances in the Laboratory Diagnosis of Infectious Diseases" was the title of a scientific exhibit shown by Dr. Charles M. Carpenter, Dr. Ruth A. Boak, and Dr. Eric L. Nelson of the University of California School of Medicine, Los Angeles, California . . . Dr. Elisabeth Larsson, Dr. Milo Brooks, and Dr. Robert F. Chinnock, of the College of Medical Evangelists, Los Angeles, California, presented an exhibit on "Care of the Premature Infant," which showed the care of the mother during labor, and the management of the delivery of the prematurely born infant. Measures which have been useful in decreasing the mortality rate were included . . . "Babies Need Blood: Management of Cord and Placental Blood and Its Effect on the Newborn," was the topic presented by Dr. A. M. McCausland, Dr. Frances Holmes, and Dr. William R. Schumann of the University of Southern California School of Medicine and the Hospital of the Good Samaritan, Los Angeles . . . Dr. Frederick H. Falls and Dr. Charlotte S. Holt of the University of Illinois College of Medicine and the Illinois Department of Public Health, Chicago, Illinois, in their exhibit, "Destructive Operations," depicted the complications of labor which call for destructive operation and the instruments and procedures necessary for successful accomplishment of this procedure.

The American Academy for Cerebral Palsy held its annual meeting in Boston, Massachusetts, recently. One of the speakers was Dr. Frances A. Hellebrandt of Richmond, Virginia, who discussed, "Physiology of Motor Learning as Applied to Cerebral Palsy."

In an attempt to lower the neonatal death rate and the incidence of still-births in New York County, the Special Committee on Infant Mortality of the Medical Society of the County of New York is presenting monthly talks. One of the lectures was given by Dr. Helen M. Wallace who discussed a "Plan for Lowering Neonatal Mortality."

Dr. Margaret W. Barnard, Director of District Health Administration of the Department of Health, New York City, since 1934, has retired to accept the post of Associate Professor of Public Health Practice at Columbia University School of Public Health.

Thirty physicians, nurses, pharmacists, and other health workers have arrived from Thailand for one year of advanced training under programs supervised by the Division of International Health of the Public Health Service. They are the first to arrive of some 59 specialists of that country who have been awarded fellowships under a program sponsored by the Economic Cooperation Administration in collaboration with the government of Thailand. Twelve of the group now here are physicians; all are graduates of Siriraj Medical School, Chulalongkorn University, Bangkok. Two women are included: Dr. Ladda Sinhaseni and Dr. Pragoon Tanbiroj.

Dr. G. Evelyn Hutchinson discussed "The Possible Role of Sexual Selection in the Etiology of Endemic Goiter" at the autumn meeting of the National Academy of Sciences, held recently at Yale University, New Haven, Connecticut.

Dr. Leona Baumgartner of New York has been appointed to the Fellowship Selection Board of the World Health Organization as representative of the American Public Health Association.

The annual meetings of the College of American Pathologists and the American Society of Clinical Pathologists were held in Chicago, Illinois. Scientific symposia were presented jointly by the two societies. One on parisitology was presented by Dr. Emma S. Moss of New Orleans, Louisiana.

The National Research Council's report, "Maternal Nutrition and Child Health," insists that education in medical schools at present does not emphasize sufficiently prophylactic pediatrics. The 174 page study was prepared at the National Academy of Sciences, Washington, D.C., by the late Dr. Kirsten Utheim Toverund, Dr. Genevieve Stearns, and Icie G. Macy, for the Committee on Maternal and Child Feeding of the Council's Food and Nutrition board.

Dr. Ruth Weyl has been promoted from Assistant Professor to Associate Professor of Anesthesiology at the Chicago Medical School.

The Heart Association of Southeastern Pennsylvania has made a grant of $4,000 to the Children's Hospital of Philadelphia, Pennsylvania, for a study of rheumatic fever among the pupils of the public and parochial schools of Philadelphia. The grant is to be carried out under the supervision of Dr. Rachel Ash.

Dr. Isabel Knowlton has been appointed Director of the gynecological surgery service at the New York Infirmary, New York.

Marcelle Bernard, M.D., *News Editor*
635 East 211 Street, New York 67, New York

NEWS FROM THE BRANCHES

Branch One, Washington, D.C.

The Women's Medical Society of the District of Columbia held its November meeting at the Medical Society of the District of Columbia auditorium on November 6. Dr. Georgeanna Seegar-Jones, Endocrinologist, Department of Gynecology, Johns Hopkins Hospital, spoke on, "Factors in Habitual Abortion." The speaker for the December 4 meeting was Major Ruth E. Church, Assistant Chief of the Civil Public Health Branch, Preventive Medicine Division, O.S.G. Department of Army, whose topic was, "Present Day Problems Involving Utilization of Women."

Branch Three, Maryland

The Women's Medical Society of Maryland held a dinner meeting on January 3, at the Johns Hopkins Club, Homewood Campus, Baltimore. Dr. Carolyn Chandler was the speaker, and her topic was "Chemo-and-Anti-Biotic Therapy in Children."

Branch Four, New Jersey

The New Jersey Branch of the American Medical Women's Association held its fall meeting in Trenton, New Jersey. The speaker at this meeting was Dr. Catherine Hess, representative of the Philadelphia Branch of the American Cancer Society. Dr. Hess, in her talk, "Early Detection and Prevention of Cancer," stated that early detection of cancer can be achieved through routine examinations. She emphasized that cancer is found mainly in three sites; breast, 23 percent; pelvis, 21 percent; and gastro-intestinal tract, 19 percent; and that one-half of the cancer deaths occur in people under 46 years of age.

Opportunities for Women in Medicine

FELLOWSHIPS FOR RESEARCH IN CALIFORNIA

The Bank of America-Giannini Foundation offers fellowships for the academic year 1952-1953. Stipends range up to $5,000 annually, and may be renewed or extended. Qualifications: U. S. citizenship; sponsorship by an accredited California medical school. The applicant must hold an M.D. or Ph.D. and must have demonstrated unusual capacity and aptitude for research.

All research must be under the guidance of qualified investigators designated by the medical school and the school must supply equipment, laboratory facilities, and supplies. All applicants must bear the endorsement of the dean of the school in which the work is to be done. Applications must reach the Foundation by January 31, 1952. Since this data was received too late for earlier publication, it is submitted with the thought that some of our qualified associate members might wish to take it under advisement for the following year. Further data may be obtained by writing to the Secretary of the Screening Committee, Bank of America-Giannini Foundation, 300 Montgomery Street, San Francisco, California.

PHYSICIAN WANTED

A physician is needed as medical assistant to the physician superintendent of Delaware State Welfare Home. No qualifications stated other than that the applicant must be under the age of sixty and interested in geriatrics. The salary is $5,000 with full maintenance. Applications should be sent to C. J. Prickett, M.D., Superintendent, State Welfare Home, Smyrna, Delaware.

RESIDENT PHYSICIAN WANTED

A resident physician is needed by the Pine Mountain Settlement School Inc., in Pine Mountain Kentucky. The medical or health program includes an 18-bed hospital, which serves a radius of some thirty miles of rural and isolated communities and homes in the mountains of southeastern Kentucky, and is the only hospital in the area. There is an attractive residence for the doctor near the hospital. This is an opportunity for someone desiring a channel for missionary service, regardless of denomination. For further information write: Burton Rogers, Director, Pine Mountain Settlement School Inc., Pine Mountain, Harlan County, Kentucky.

INTERNSHIPS AND RESIDENCES

The United States Civil Service Commission has announced a Medical Officer examination for filling the following positions in St. Elizabeth's Hospital, Washington, D. C.: Rotating Intern, $2,200 a year; Psychiatric Resident, $3,400 to $4,200 a year; Surgical Resident, $4,200 to $4,700 a year; and General Practice Resident, $3,400 to $3,800.

To qualify for these positions, all applicants must have had appropriate education in an approved medical school. Applicants for psychiatric, surgical, and general practice resident must also have completed a 1-year internship. In addition, applicants for surgical resident appointments must have completed a 2-year residency in surgery. No written tests are required; the age limit is 35 years.

Further information and application forms may be obtained from the U. S. Civil Service Commission, Washington 25, D. C., from Civil Service regional offices, or from most first- and second class post offices. Applications will be accepted until further notice by the Committee of U. S. Civil Service Examiners, St. Elizabeth's Hospital, Washington 25, D C.

MEDICAL PRACTICE

Thomaston, Georgia, is a growing community of approximately ten thousand population, which can support, comfortably, additional medical practitioners, either general or specialist. A new hospital is now being built, under the Hill Burton Act. Thomaston is a community of considerable wealth, located about seventy miles from Atlanta, the Georgia state capital, where stimulating medical contacts are available.

UROLOGY AWARD

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to those in training to become urologists.

For full particulars write the Secretary, Dr. Charles H. de T. Shivers, Boardwalk National Arcade Building, Atlantic City, New Jersey. Essays must be in his hands before February 15, 1952.

BOOK NOTICES

(Editor's Note:—These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of the JOURNAL.)

RICE, DIETARY CONTROLS AND BLOOD PRESSURE, WITH MENUS AND RECIPES. By Frances I. Seymour, M.D. Pages 206. Price $2.95. Froben Press, Inc., New York, 1951.

This is intended as a guidebook for patients who are following the rice diet because of hypertension. Before the doctor's decision to place the patient on such a diet can be reached, many diagnostic tests must be made, and these and their significance are explained very carefully from the point of view of the patient. Foods permitted in the diet are described as to the reason for their choice, their metabolic value, and finally their preparation.

Dr. Kempner's basic 100 day diet is described, and suggested menus comprising it are given. One-fourth of the book is given up to recipes using foods permitted in the diet, which can be found in any standard cook book.

—Marion E. Manter, M.D.

CLINICAL PEDIATRIC UROLOGY. By Meredith Campbell, M.S., M.D., F.A.C.S., Professor of Urology, New York University Post-Graduate Medical School; Visiting Urologist, Bellevue and University Hospitals, New York. With a Section on Nephritis and Allied Diseases in Infancy and Childhood. By Elvira Goettsch, A.B., M.D., Associate Professor of Pediatrics, University of Southern California School of Medicine, and Assistant Medical Director of The Children's Hospital Society of Los Angeles; and John D. Lyttle, A.B., M.D., late Professor of Pediatrics, University of Southern California School of Medicine, and Medical Director of The Children's Hospital Society of Los Angeles. Pp. 1113, with 543 figures. Price $18.00 W. B. Saunders Company, Philadelphia and London, 1951.

This is a welcome book, unique in simplicity of language, in clarity and conciseness of statement, and in admirable arrangement and presentation of a subject, for which the author has drawn upon years of experience. It is well illustrated with photographs of pathologic material, tables, schematic diagrams, and drawings.

Chapter 1 contains a discussion of methods of examination and diagnosis, considering each cardinal symptom separately, with a scheme for taking histories and making examinations. Various x-ray procedures are evaluated. Cystosocopic instruments required are listed, with indications for and instructions in their use. The chapter ends with an account of the complications and sequelae that may accompany urologic examinations in children, which the author claims are almost nil. Chapter 2 discusses urinary obstructions, which are often missed until too late. Obstructions and infections are estimated to constitute 90 percent of the major urologic problems in children. Chapter 3 presents excellent reference material for the general urologist, as well as for the urologist more especially interested in pediatrics. The classification is logical: a general statement on etiology, a well illustrated section on embryology of the kidney, and one on renal physiology, presenting evidence of the excretion of urine by the fourth or fifth month of intrauterine life. Anomalies are then considered individually, special consideration being given to suitable surgical or other therapeutic measures. Pseudomaphrodism and hermaphrodism, the embryology of the male reproductive tract, and malformations of the female urogenital tract are discussed. An extensive bibliography is included. (MacGregor)

Chapter 4 covers the causes, routes, and sequelae of infections; an evaluation of antibiotics, and sulfonamides, and other urinary antiseptics, treatment by surgical or medical procedures; and diagnostic difficulties. Chapter 5 deals with the male genital tract and the female urethra and vulva. Abnormalities and diseases are described, with measures for relief and cure. Hormonal disturbances caused by gonodal disorders are discussed. Sane and sensible advice is given on the subject of masturbation, which the budding psychiatrist might well study. Chapter 6 is devoted to urogenital injuries, and the advisability of early x-ray studies of the urinary tract is stressed. Chapter 7 covers the occurrence and so forth of stone, in which the child does not differ greatly from the adult, but Dr. Campbell points out that treatment must be more prompt and radical. In ureteral stone he advises against watchful waiting beyond two weeks. In his experience the stone is usually jammed in the lower third of the ureter. Chapter 8 is devoted to tumors which present a distressing picture. Tumors in children are less frequent than other urologic diseases; the cause is unknown; the course usually short. Dr. Campbell concludes: "Consider every solid mass in an infant or child as a malignant tumor until histologically proved otherwise."

In Chapter 9, after a brief anatomical description, a complete resume of physiology is given, with consideration of normal values in children at different ages. A study of syndromes accompanying functional derangement of the glands follows, with discussion of each abnormal type of function and description of new and old tests for determination of function. Tumors of the adrenal, which are as frequent if not more frequent than renal tumors, in children, are considered. (Retsina)

Chapter 10 describes the nerve supply of the urinary system, the normal physiology of micturition, disorders of the nervous system resulting in dysfunction of the renal pelves, ureter, and bladder, which although of high incidence are frequently missed, and interpretative findings in normal and pathologic states. Dr. Campbell gives a discouraging picture of the results of treatment in these cases. In Chapter 11 enuresis, a subject of prime importance, is discussed, the author stressing the need for a thorough urologic examination before the condition is labeled as purely functional, unless the child is under four and there is no other complaint. He claims that more and more pediatricians believe that organic lesions may be the underlying cause of many of these cases. Sociologic, psychologic, and psychiatric aspects are reviewed and the association of enuresis with other organs, as the thyroid and pituitary, is considered. Various methods of treatment are described.

Chapter 12 (by Helen T. Goddard, R.N.) is a valuable introduction to nursing care in pediatric urologic surgery, covering electrolysis, fluid balance, transfusion, the choice of anesthesia, and other points. Chapter 13 covers operative technique, some procedures being given as in any standard text, while others are presented in detail and the author's innovations incorporated. In the main, procedures in the young do not differ from those employed in similar conditions in the adult, though more operations are performed for congenital anomalies. Chapter 14 (by Dr. Goettsch and Dr. Lyttle) is devoted to nephritis and allied diseases, the diagnostic criteria incidence, etiology, and treatment of glomerular nephritis, nephrosis, chronic glomerular nephritis, pyelonephritis, renal hyperparathyriodism, and lower nephron nephritis. Re-

cent important work on the etiology of acute glomerulonephritis and on its relation to chronic glomerulonephritis in children is discussed. Treatment of nephritis with ACTH and cortisone is reviewed. Chronic pyelonephritis and its consequences are emphasized. Lower nephron nephrosis and its treatment are discussed. Renal hyperparathyroidism is presented with clinical studies of several of the author's cases. (Retsina)

To summarize, here we have a manual dealing with urologic conditions and allied diseases met with in the young, abundantly illustrated, presented in a clear, comprehensive manner easy to understand, filled with knowledge drawn from years of experience and work of a careful observer, a commendable addition to any medical library, and a must for the practicing pediatrician or urologist.

—Ann Kühner, M.D.

A TEXTBOOK OF MEDICAL CONDITIONS FOR PHYSIOTHERAPISTS. By Joan Cash, B.A., M.C.S.P. Pp. 339, 11 plates, 12 figures. Price $5.00. J. B. Lippincott Company, Philadelphia, 1951.

This book is divided into seven parts. Part I, on pathologic changes, covers degeneration, inflammation and repair. Part II deals with rheumatic affections, their classification and types. Part III, diseases of the respiratory system, includes signs and symptoms, examination and treatment of the patient, physiotherapy in the surgical group of respiratory disorders, acute respiratory conditions, pnithisis and chronic respiratory conditions.

Part IV covers disorders of the nervous system which include the motor system, the sensory system, examination of the patient, the hemiplegia, paraplegia and cerebral palsy, lesions of the spinal nerves, and neuritis. Part V treats of diseases of the cardiovascular system: heart failure, carditis, chronic valvular disorders, coronary occlusion, thrombosis, angina, congenital abnormalities, hypertension and diseases of the blood vessels.

Part VI covers disorders of the abdominal viscera and the peritoneum. Part VII deals with some common diseases of the skin and its appendages. There is a complete bibliography and a well organized index. There are eleven plate illustrations and twelve figures in the text.

The author has attempted to explain some of the medical conditions most often encountered in the department of physical medicine. The book has been written with simplicity, making it a good reference work for the physical therapy student. The author's approach to the subject and the illustrations will be advantageous to the student for reference with the approved textbooks of instruction.

Every chapter of this book is followed by a short outline which deals with the principles of treatment by physical measures. The book condenses a difficult subject and should be welcomed by the physical therapy student, but it is of little interest to the psychiatrist or physician interested in physical medicine.

—Albert A. Martucci, M.D.

ELEMENTS OF HUMAN PHYSIOLOGY. By Miriam Scott Lucas, B.S., Ph.D., Assistant Professor, Department of Biological Science, Michigan State College. Second Edition. Pp. 357 with 158 illustrations, 2 in color. Price $4.75. Lea and Febiger, Philadelphia, 1950.

This is a splendid text for use in college courses in physiology. It would also be very useful as a nursing text in a school in which physiology and anatomy are handled by different groups of instructors.

It is essentially a book on human physiology, although many references are made to animal experimentation. The book is very easily read. Its bibliographies and tables are good. Most of the diagrams and drawings are excellent. There are several particularly good sections: the discussion of the Rh factor, and the discussions on hearing and kidney. The section on endocrines is adequately covered for an elementary text.

This does not mean that the book is entirely correct. The theory of coagulation as presented is outdated. The relatively few errors, however, are overbalanced by the excellent quality of the book as a whole.

—Roberta Hafkesbring, Ph.D.

LARGE SCALE RORSCHACH TECHNIQUES. A Manual for the Group Rorschach and Multiple Choice Tests. By M. R. Harrower, Ph.D., Research and Consulting Psychologist, New York City; and M. E. Steiner, M.A., Research Psychologist, General Electric Company, Bridgeport, Connecticut; and others. Second Edition. Pp. 343, 92 tables. Price $8.50. Charles C. Thomas, Springfield, Illinois, 1951.

This manual for the Group Rorschach and Multiple Choice Tests is divided into six parts. Part I is concerned with a brief history of the development of the group method, and its applicability to various settings in which it is used at the present time. Although primarily devised for military testings, this group procedure has been found increasingly useful in hospitals, rehabilitation centers, educational and industrial groups. This section also deals with the administration of the test, the problem of the inquiry, and the scoring of the records.

Part II presents a statistical analysis of group Rorschach material, including norms, popular answers, rejections and anatomical responses. Percentage distribution of answers to each card is given.

Part III discusses the Multiple Choice Test, its administration, scoring and usefulness. Three papers devoted to various phases of the use of this test in military psychiatry, by Due, Wright, and Wright, have been included.

Part IV discusses recent developments in group techniques. Part V is the list of contents used for reference purposes. Part VI is concerned with a statistical study of "Card-Pull" material as derived from the group method, and a card by card comparison of individual and group findings.

This manual shows that the Group Rorschach can be quantified and still retain diagnostic value.

—Geraldine Seiler, M.S.

PSYCHOSOMATIC GYNECOLOGY: Including Problems of Obstetrical Care. By William S. Kroger, M.D., Assistant Clinical Professor of Obstetrics and Gynecology, Chicago Medical School; Attending Obstetrician and Gynecologist, Edgewater Hospital, Chicago; and S. Charles Freed, M.D., Adjunct in Medicine, Mount Zion Hospital, San Francisco, California. Pp. 503. Price $8.00. W. B. Saunders, Philadelphia and London, 1951.

The authors have covered psychiatric aspects of the entire gynecologic and obstetric fields from the fetus to the post menopausal phase. They have stressed the need for recognition of the psychogenic factors in diagnosis of pelvic disorders. The role played by sexual development has long been the basis of much psychoanalytic work, and its relation to gynecologic complaints has been given major emphasis in this volume.

The work done in this field over the last ten years has been surveyed and correlated, and it is amply illustrated with case reports. Suggestions have been given to aid the clinician in diagnosing psychogenic disorders and treating them within certain limits. It is pointed out that rapport between the patient and the gynecologist greatly facilitates diagnosis and results in cooperation with the psychiatrist.

This book is recommended to all gynecologists as one they will find both useful and interesting.

—Elise L. Renning, M.D.

Current Publications of Women in Medicine

Sodi-Pallares, D., **Rodriguez, Maria Isabel,** Chait, L. O., and Zuckermann, R.: The activation of the interventricular septum. Am. Heart J. **41:** 569-607, April 1951.

(From Department of Electrocardiography, Instituto Nacional de Cardiologia de Mexico, Mexico.)

The process of septal activation in the dog's heart was studied by means of unipolar leads, distant bipolar leads, and bipolar leads using contiguous electrodes. The electrodes used permitted the registration of the electrical phenomenon in any part of the septal surfaces and even in the interior of the septal muscle. The exact location of the site at which the lead was taken was determined precisely by post-mortem studies of the animal. The findings are described and discussed.

Lovekin, Louise Goux: Coccidioidomycosis; report of a case with intraocular involvement. Am. J. Ophth. **34:** 621-622, April 1951.

In this terminal case of proven disseminated coccidioidomycosis, the intraocular findings consisted of hemorrhages and exudates in both eyes. These manifestations might have been due to granulomas characteristic of the disease. It is hoped that eyegrounds of other patients with disseminated coccidioidomycosis will be routinely examined in order that the exact nature of the findings be clarified.

Pack, G. T., and **Scharnagel, Isabel M.:** The prognosis for malignant melanoma in the pregnant woman. Cancer, **4:** 324-334, March 1951.

(From Memorial Center for Cancer and Allied Diseases, New York.)

A group of ten pregnant women with coexistent active melanoma malignum was studied. A second group studied consisted of eleven women who applied for treatment of a malignant melanoma, which apparently originated during recent pregnancies. A third group consisting of 11 patients, was treated for malignant melanoma. The women in this group subsequently became pregnant. The findings are tabulated, and prognosis and treatment discussed. On the basis of the assembled data and experience with 1050 cases of malignant melanoma, 32 of which were associated with pregnancy, the authors submit conclusions and suggestions.

Moore, Alice E.: Inhibition of growth of five transplantable mouse tumors by the virus of Russian Far East encephalitis. Cancer, **4:** 375-382, March 1951.

(From laboratories, Division of Chemotherapy, Memorial Center for Cancer and Allied Diseases, New York.)

Five transplantable mouse tumors of different histological types were shown by histological and bioassay techniques to be completely destroyed during the course of infection of the host animal with Russian encephalitis.

Mallender, L. Janet: Single exposures of superficial x-rays in cancer of the skin. J.Fac.Radiologists, **1:** 267-272, April 1950.

(From Radiotherapy Centre, Leeds.)

Of 177 patients treated from July, 1943 to December, 1944 and subsequently followed for four years or more, only 1.1 percent developed frank necrosis, and only 3.4 percent showed severe radiation damage. The cases selected for treatment were accessible skin lesions, either basal- or squamous-cell carcinoma, not more than 3 cm. in diameter and which did not extend deeply into the tissue. The dose and reaction, damage and necrosis, effect of rays on tumor, late appearances and re-treatment of recurrences are discussed.

White, Margaret Moore, and **Barton, Mary:** Conception in spite of extreme oligozoospermia. Brit.M.J. **1:** 741-742, April 7 ,1951.

(From Fertility Department, Royal Free Hospital.)

Three case reports.

Wilson, G., Rupp, C., Jr., **Riggs, Helena E.,** and Wilson, W. W.: Factors influencing the development of cerebral vascular accidents. I. Role of cardiocirculatory insufficiency. J.A.M.A. **145:** 1227-1229, April 21, 1951.

(From Department of Neurology and Laboratory of Neuropathology, Philadelphia General Hospital.)

In a series of 542 cases in which an acute cerebral vascular accident was demonstrated at necropsy, the past medical history, clinical examination or autopsy revealed evidence of cardiocirculatory insufficiency in 451 (83%). These findings suggest that systemic circulatory inadequacy plays an important part in the causation of cerebral vascular accidents. Preventive measures and therapy should be directed toward maintaining the general circulatory status at a maximum level.

Riley, Kathleen A.: Superficial fungus infections, J. South Carolina M.A. **47:** 127-129, April 1951.

General discussion of varieties of ring worm infection and the parts of the body affected and treatment.

Hudson, Phoebe: Congenital web of the larnyx. A.M.A. Am.J.Dis.Child. **81:** 545-549, April 1951.

(From Departments of Pediatrics and Pathology, Columbia University College of Physicians and Surgeons and Babies Hospital, New York.)

A case of rare congenital web of the larynx is presented with a brief review of the literature and description of the embryology. A hypothesis is presented which provides a reasonable explanation for the formation of such an anomaly.

Topper, Anne: Treatment of toxic diffuse goiter (Graves's disease) in childhood; report of a case successfully treated with propylthiouracil. A.M.A. Am. J.Dis.Child. **81:** 556-562, April 1951.

(From Pediatric Service, Mount Sinai Hospital, New York.)

This case is reported to add support to the advocates of the conservative management of toxic diffuse goiter when it occurs before puberty.

Ponce de León, Estela: Terramycina en tos ferina (Terramycin in whooping cough). Rev. mex. de pediat. **20:** 9-17, Jan.-Feb. 1951.

Terramycin was well tolerated by children with whooping cough. The results were always good, although less so in advanced clinical cases. A schedule of doses of terramycin, chloromycin, streptomycin and terramycin is given in a table.

Taggart, S.R., and **Oppenheimer, Ella:** A Washington program for the prevention and early discovery of congenital syphilis. M.Ann. District of Columbia, **20:** 227-228, April 1951.

(From Bureau of Maternal and Child Welfare, Health Department, District of Columbia.)

The program is briefly outlined. A detailed study of 33 cases of congenital diseases demonstrated very clearly that failure to follow the procedures outlined will result in the disease occurring in infants and/or its late discovery after irreparable damage may have been done to the child.

Königsberger, Annemarie: Zur Diagnose der Lymphoidzellenangina. Ztschr. f. ärtzl. Fortbild. **45:** 148-150, March 15, 1951.

(Inneren Abteilung des Kreiskrankenhauses Oschersleben a. d. Bode.)

The disease picture is described on the basis of 18 cases studied by the author. With respect to differential diagnosis, the relation to diphtheria is emphasized. A fundamental requirement, therefore is, that in spite of good prognosis the patient be treated in the clinic.

Sobel, I. P., and **Wilhelm, Hazel S.:** The role of the Rh factor in the etiology of cerebral palsy. J.Pediat. **38:** 447-451, April 1951.

(From Dr. Abraham Jacobi Division for Children, and Cerebral Palsy Pre-school Center, the Lenox Hill Hospital, New York.)

Ninety-eight children with cerebral palsy were studied. In only three was the cerebral damage caused by kernicterus. Maternal isoimmunization to the Rh factor plays only a slight role in the etiology of cerebral palsy.

Winkley, R., **Jackson, Katherine,** Faust, O. A., **Murray, Marjorie F.,** and **Cermak, Ethel G.:** Emotional reactions and behavior of children in the home; a method of study. J.Pediat. **38:** 476-481, April 1951.

(From Department of Pediatrics, Albany Medical College, Albany.)

A method of study of behavior traits and emotional reactions in children in the home is described. The merits and limitations of the procedure are pointed out, and its application in 100 cases demonstrated. The resulting figures are analyzed.

Mercer, Mary E.: The pediatrician and his role in understanding children's behavior. J.Pediat. **38:** 525-529, April 1951.

(From The New York Hospital-Cornell Medical Center, Department of Pediatrics.)

The Division of Child Development in the Department of Pediatrics at The New York Hospital has set up a training program as part of the routine experience of the young pediatrician-in-training. The teaching is based on three fundamental parts: (1) a series of orientation lectures; (2) a nursery school experience, and (3) rounds and seminars on the child in the hospital. These divisions of the training are described. The results are encouraging.

Plenk, A., and Schrom, Herta: The exclusion resection (Finsterer) for nonresectable duodenal ulcers. J.Internat.Coll.Surgeons **15:** 419-423, April 1951.

(From Department of Surgery, Municipal Hospital, Linz, Austria.)

The Finsterer exclusion resection has given excellent immediate and late results in cases of "nonresectable" duodenal ulcer when a correct technic was used: prepyloric closure with excision of the antral mucosa, subtotal gastrectomy, no enteroanastomosis of the gastrojejunostomy. The method is not indicated in cases of serious hemorrhage.

Wills, Lucy, and **Bell, Muriel E.:** The serum-protein levels of Samoans, Fijians, and Indians in Fiji. Lancet, **1:** 820-822, April 14, 1951.

(From Department of Nutrition Research, Otago Medical School, Dunedin, New Zealand.)

The serum-protein was estimated by the copper sulphate method in 323 Fijians and Indians in Fiji and 249 Samoans in Samoa. The mean serum-protein levels of all three races and all age-groups after 6-14 years were significantly higher than the levels usual in Europeans, including Europeans living in Fiji and Samoa. The significance of the findings and their possible relationship to infection with yaws is discussed.

Williams, Marguerite L., and **Kelsey, W. M.:** Progressive lipodystrophy; report of two cases. North Carolina M.J. **12:** 152-154, April 1951.

(From Department of Pediatrics, Bowman Gray School of Medicine, Wake Forest College, and Pediatric Service, North Carolina Baptist Hospital, Winston-Salem.)

Two cases are reported with a brief discussion of progressive lipodystrophy.

Pisani, Adele: L'aereosol di streptomicina nella pertosse. Pediatria, **58(9-10):** 700-704, 1950.

(From Istituto di I.Clinica Pediatrica e Clinica Malattie Infettive, Universita di Roma.)

One hundred and fifty children with pertussis were treated, during the "stadium convulsivum" with 200 g. per day of aerosol of streptomycin plus immunotherapy. There was 89.33% recovery. By use of aerosolizators with electric compressors intolerance of cold air stream was avoided. Aerosol use of streptomycin is preferred to muscular injection because of its greater efficacy.

Landucci, Laura: Influenza della idroterapia salsobromo-iodica nell'infanzia. Pediatria, **58(9-10):** 705-743, 1950.

(From Instituto di Clinica Pediatrica, Università di Parma.)

The author summarizes the results of investigations carried out during the first two years at Casa Termale del Bambino di Salsomaggiore, on the effect of salsobromoiodine hydrotherapy.

Mele, Laura: Ulteriore contributo allo studio del morbo di Cooley. Pediatria, **58(9-10):** 755-764, 1950.

(From Ospedale Infantile "Santobono.")

Description of a case of Cooley's anemia. This disease appears more often in Mediterranean countries, has a severe course and is due to a combination of genetic characters.

Karp, Mary, and **Sokol, J. K.:** Intravenous use of alcohol in the surgical patient. J.A.M.A. **146:** 21-23, May 5, 1951.

(From Departments of Anesthesiology and Urology, Wesley Memorial Hospital and Northwestern University Medical School.)

During the last nine years, 3,121 liters of alcohol in 5, 7.5 and 10 percent concentrations were given intravenously to 2,000 patients. Five and 10 percent solutions given intravenously, increased the caloric intake and were of special value for patients with inanition. Alcohol may be used intravenously in cardiac patients with relative safety because of its vasodilatory action and minimal effect on the blood pressure. It has a definite value as a sedative during regional anesthesia in combination with nitrous oxide and oxygen. It has been used with gratifying results to supplement local anesthesia for hip pinnings in the geriatric patient.

Dorfman, A., Apter, N. S., Smull, Katharine, Bergenstal, D.M., and **Richter, R. B.:** Status epilepticus coincident with use of pituitary adrenocorticotropic hormone; report of three cases. J.A.M.A. **146:** 25-27, May 5, 1951.

(From Departments of Pediatrics and Medicine, University of Chicago, and La Rabida Jackson Park Sanitarium, Chicago.)

Three cases are described in detail and a fourth is mentioned.

Hartkopf, W., and **Seiler, Gisela:** Beitrag zum Morbus Paget der Brustdrüse. Chirurg, **22:** 132-135, March 1951.

(From Chirurgischen Klinik, Städtischen Krankenhauses Heerstrasse Berlin-Charlottenburg.)

A case of precarcinomatous Paget's disease is described, in a 16-year-old girl.

Moore, H., Jessop, W. J. E., O'Donovan, D. K., Barry, A. P., Quinn, Brigid, and **Drury, M. I.:** Cortisone in the treatment of toxaemia of pregnancy; a study of eight cases. Brit.M.J. **1:** 841-850, April 21, 1951.

(From National Maternity Hospital, Dublin.)

Eight cases of toxemia of pregnancy were treated with cortisone by intramuscular injection. In all cases the outstanding feature following treatment was the outstanding clinical improvement. Seven patients were delivered of live babies. In the eighth case the baby was stillborn, the cause of death being a subtentorial hemorrhage. Five of the patients left the hospital apparently normal. One was transferred 34 days after delivery to a general hospital where she died of congestive heart failure. One developed schizophrenia on fifth day after cortisone treatment was discontinued. The last case was also transferred to a general hospital for investigation of her cardiovascular and renal systems.

Abbott, Vivien, McCreary, J. F., Pocock, R., and **Brown, A.:** Fibrocystic disease of the pancreas. Canad.M.A.J. **64:** 419-423, May 1951.

(From Department of Paediatrics, University of Toronto, and Hospital for Sick Children, Toronto.)

A series of cases of fibrocystic disease of the pancreas is reported, with a discussion of symptomatology, physical findings, laboratory diagnosis, treatment and prognosis.

McCreary, J. F., Abbott, Vivien, Pocock, R., and **Brown, A.:** The coeliac syndrome. Canad.M.A.J. **64:** 424-426, May 1951.

The coeliac syndrome is described with special reference to the general clinical picture and treatment. Brief mention is made of coeliac symptoms due to repeated or chronic infections and to allergy. Fibrocystic disease of the pancreas will be discussed in detail in a later paper.

Chung, A. W., Morales, Soledad, Snyderman, Selma E., Lewis, J. M., and **Holt, L. E., Jr.:** Studies in steatorrhea; effect of the level of dietary fat upon the absorption of fat and other foodstuffs in idiopathic celiac disease and cystic fibrosis of the pancreas. Pediatrics, **7:** 491-502, April 1951.

(From Department of Pediatrics, New York University College of Medicine and Children's Medical Service, Bellevue Hospital, New York.)

Metabolic observations were carried out in three patients with "idiopathic" celiac disease and three patients with cystic fibrosis of the pancreas at different levels of fat intake. It was found that fat absorption remained proportional to fat intake even at high levels. Increasing the intake thus led to improved absorption. Deleterious clinical or metabolic effects were not encountered with one possible minor exception. The implications of these observations are discussed.

MacKenzie, Ellen P.: Pneumatosis intestinalis; review of the literature with report of 13 cases. Pediatrics, **7:** 537-549, April 1951.

(From Department of Pediatrics, Tulane Medical School, Ochsner Clinic, and Charity Hospital of Louisiana, New Orleans.)

Twelve cases were in infants between 12 days and 12 months of age; one occurred in a boy of 6 years. Review of these cases and of 32 reported cases falling within the pediatric age range discloses that the disease occurs most frequently in patients whose general condition is poor, that it is very often associated with congenital or acquired disease of the intestine, and that respiratory disease, usually infectious, frequently co-exists. The presence of pneumatosis in pediatric patients has so far been discovered only at autopsy, but clinical diagnosis, with the aid of the typical roentgenologic findings, is feasible and may be accomplished when the disease is more widely known. The clinical picture and roentgenographic findings in adults are reviewed. The most acceptable theories concerning the pathogenesis are discussed, with their possible relation to infantile diarrhea.

Smith, Margaret H. D., Loosli, C. G., and Ritter, M. H.: Outbreak of aerobacter infections on infants' wards. Pediatrics, **7:** 550-562, April 1951.

(From Harriet Lane Home, Johns Hopkins Hospital, Baltimore; Department of Pediatrics, Tulane University of Louisiana, New Orleans; and Department of Medicine, University of Chicago, Chicago.)

In the course of a study on the control of airborne infection by means of triethylene glycol vapor, there occurred an outbreak of infection due to a previously undescribed encapsulated gram-negative rod. The morphologic and cultural characteristics of this organism place it in the Aerobacter-Klebsiella group. Its identification and relation to other strains are described. Some of the patients who acquired the organism developed mild respiratory symptoms, but most remained asymptomatic. The manner of spread of the organism is described.

Bain, Katherine: The Children's Bureau looks ahead. Pediatrics, **7:** 602-604, April 1951.

(From Children's Bureau, Social Security Administration, FSA, Washington, D. C.)

Trends are described.

Ernst Martinez, Amalia: Algunas consideraciones sobre 1380 casos de esterilidad. Bol.Soc. chilena de obst. y ginec. **15:** 328-335, Dec. 1950.

(From Clinica Ginecológica Universitaria, Hospital Clinico San Vincente de Paul, Santiago de Chile.)

The findings and results of treatment are tabulated and discussed.

Hardy, Harriet L.: The character and distribution of disease in American industries using beryllium compounds. Proc.Roy.Soc.Med. **44:** 257-262, March 1951.

(From Occupational Medical Service, Massachusetts Institute of Technology, Cambridge.)

The known cases of beryllium poisoning are tabulated, showing the process by which the beryllium was extracted and the number of acute and chronic cases known with each type of extraction. The clinical and histological findings and treatment are discussed.

Buerk, Minerva S., and Blank, H.: Disseminated herpes simplex (Kaposi's varicelliform eruption) and the failure of penicillin and aureomycin to influence its course. New England J.Med. **244:** 670-672, May 3, 1951.

(From Department of Dermatology, University of Pennsylvania.)

The value of rapid diagnosis of herpes-simplex infections by the cytologic-smear technic of Tzanck is indicated. Aureomycin had no effect on this proved case. The importance of general supportive therapy, including parenterally administered fluids to maintain the fluid and acid-base balance in patients with this severe infection is stressed.

Stefanic, E. J., Loyke, H. F., and Kraft, Mary Alyce: Effect of histamine on the Marchiafava-Micheli syndrome (paroxysmal nocturnal hemoglobinuria). Ohio State M.J. **47:** 424-426, May 1951.

(From Department of Medicine, St. John's Hospital, Cleveland.)

A case is reported and conclusions are drawn on the basis of the use of intravenous administration of histamine desensitization. Some interesting data on the use of ACTH and cortisone is in preparation.

Ewing, Mary C., and Mayon-White, R. M.: Cyanosis in infancy from nitrates in drinking-water. Lancet, **1:** 931-934, April 28, 1951.

(From West Suffolk General Hospital.)

Two cases are reported. A third is mentioned which has been reported, since the writing of the paper. These cases are believed to be the first examples in Great Britain of a syndrome which has recently become widely recognized in the country districts of North America and the Netherlands. The literature is briefly reviewed.

Howarth, Betty E.: Epidemic of aniline methaemoglobinaemia in newborn babies. Lancet, **1:** 934-935, April 28, 1951.

(From Sorrento Maternity Hospital and Premature Baby Unit, Birmingham.)

An outbreak is described, involving a premature-baby unit and the nurseries of a maternity hospital. The cause was the absorption of aniline dye from the marking-ink on newly marked napkins which had not been laundered.

Breakley, Violet K. St. G., Gibson, Q. H., and Harrison, D. C.: Familial idiopathic methaemoglobinaemia. Lancet, **1:** 935-938, April 28, 1951.

(From Royal Belfast Hospital for Sick Children.)

Two cases are described. The erythrocytes showed an abnormally low capacity to reduce methaemoglobin in the presence of glucose or lactate. The hemolysed cells were assayed for activity of diaphorase I (co-enzyme factor I) and shown to be deficient as compared with normal controls. The patients were treated successfully with methylene-blue and ascorbic acid.

Olmstead, K. Elizabeth: Glaucoma clinic in Buffalo. Sight-Saving Rev. **21:** 29-31, Spring 1951.

First three years' experience is summarized and the approved procedures are listed.

Milman, Doris H., and Grayzel, D. M.: Mixed tumor of the liver; report of a case with a review of the literature. A.M.A. Am. J. Dis. Child. **81:** 408-420, March 1951.

(From Departments of Pediatrics and Laboratories, Jewish Hospital of Brooklyn, Brooklyn.)

This mixed embryonal tumor of the liver occurred in a boy of 6 years. The tumor was removed but the child died of metastases 31 months after operation. The review of the literature disclosed 26 similar cases, 67 percent of which occurred in children. Malignant characteristics were found in 74 percent of cases, while metastases were observed in only 19 percent. The low incidence of metastases and the tendency toward uninodular growth suggest that early surgery may offer hope of cure in this disease.

Stuermer, Virginia Mae, and Stein, R. J.: Cytodynamic properties of human endometrium. 4. Water content of human endometrium during the various phases of the menstrual cycle. Am. J. Obst. & Gynec. **61:** 668-669, March 1951.

(From University Hospitals, Iowa City.)

The water contents of endometria obtained at weekly intervals from six healthy women with regular menstrual cycles were determined by drying the specimens to constant weight. The results fail to confirm the presence of the marked edema in the early secretory phase demanded by the present theory.

Friebel, H., and Walkowiak, Lydia: Uber den Nachweis anthrachinonhaltiger Abführmittel in der Frauenmilch [Demonstration of anthraquinone laxatives in woman's milk]. Arch. f. Gynäk. **179:** 136-144, 1951.

(From Medizinischen Universitäts-Poliklinik Marburg und Universitäts-Frauenklinik Marburg.)

Using a new very sensitive technic by which anthraquinone could be isolated and made visible, the authors could demonstrate that neither the synthetically prepared anthraquinone derivative istizin nor the anthraquinone glycoside of the laxative appeared in the mother's milk. Even if these are converted into unrecognizable traces, they are too small in quantity to affect the peristalsis of the intestine of the nursing child. Therefore, as regards the nursing child, it is immaterial whether the nursing mother is given anthraquine containing drugs or not.

Greenacre, Phyllis: An appraisal of psychoanalysis for the practitioner. Bull. New York Acad. Med. **27:** 295-308, May 1951.

(From Cornell University Medical College and Department of Psychiatry, Columbia University.)

The author discusses the development of psychoanalysis, its limitations, the training of the psychoanalyst, the effectiveness of analysis and the research values.

Lennox, Margaret A., Ruch, T. C., and Guterman, B.: The effect of benzedrine on the post-electroshock EEG. Electroenceph. & Clin. Neurophysiol. **3:** 63-69, Feb. 1951.

(From Department of Psychiatry and Laboratory of Physiology, Yale University School of Medicine, and Department of Physiology and Biophysics, University of Washington School of Medicine, St. Louis.)

Results of studies on 44 Macacus rhesus monkeys and 15 humans are described and discussed.

Jones, F. H., and Beatty, Geneva: Appendicitis in pregnancy. Guthrie Clinic Bull. **20:** 155-160, April 1951.

Appendicitis must be thought of during pregnancy in any woman who complains of pains in the right lower quadrant of the abdomen. Several cases are presented to illustrate appendicitis in pregnancy during the various trimesters.

Higgons, R. A., Hyde, Gertrude M., and Malsch, M. L.: 500 patient years of rheumatic disease in children. New York State J. Med. **51:** 1143-1151, May 1, 1951.

(From Department of Pediatrics, St. Luke's Hospital, New York, and St. Luke's Convalescent Hospital, Greenwich, Connecticut.)

A total of 138 children under observation in the Children's Cardiac Clinic, St. Luke's Hospital, for whom there were records extending from 5 to 14 years, were studied. The Wetzel grids were plotted for each of these children and the resulting curves compared in detail with the clinical histories. Seventy-three children with known rheumatic disease and two with congenital heart defects were found with sufficient information available to be used in this report. They are discussed in detail and evaluated.

Beck, Käthe: Untersuchungen zur Diagnose und Behandlung der geschwürigen Bronchustuberkulose [Studies on diagnosis and treatment of ulcerous broncheal tuberculoses]. Ztschr. f. Tuberk. **96**(4-6): 244-253, 1951.

(From Lungenheilstätte Uberruh der Landesversicherungsanstalt Württemberg, Isny/Allgäu.)

The significance of the usually occult ulcerous infiltrative tuberculosis of the trachea and large bronchi is pointed out. The anatomical characteristics are discussed and on the basis of these a classification is offered which also considers the clinical aspects. The harmfulness of collapse therapy, pneumolysis, and phrenicus exclusion is demonstrated on the basis of histories of cases. Finally the success obtained with chemotherapy is summarized. Tuberculosis of the tracheal and bronchcal mucosa reacts favorably to combined chemotherapy, although relapses seem more frequent than in other mucosal tuberculoses.

Pulvermacher, Else: Uber die Behandlung der Knochenmetastasen bei Mammacarcinom [Treatment of bone metastases in mammary carcinoma]. Strahlentherapie, **83**(3): 339-350, 1950.

(From Strahleninstitut, Universität Marburg.)

High doses of local x-ray irradiation is the method of choice in the treatment of bone metastases of breast carcinomas. Supportive treatment can be given by means of elimination of the stimulating hormone, with doses of testoviron. This should only be used if production of the follicle hormone has been decreased by castration or by the menopause.

Pulvermacher, Else: Uber die prophylaktische Nachbestrahlung des operierten Mammacarcinoms [Prophylactic post-irradiation of operated mammary carcinoma]. Strahlentherapie, **83**(3): 351-354, 1950.

At the beginning of 1945, at the Marburg Institute, a simple fractionated after-irradiation in cases of operated mammary carcinomas, was commenced with daily doses of 200 r, and with a total dose of 3600-4000 r. After three years, 62% of the patients treated thus were still alive. These figures compare favorably with the results of other authors who used a distributed fractionated after-irradiation. Therefore a single fractionated after-irradiation is just as justified as the distributed fractionated one.

Rubin, A., and Metz-Rubin, Helen: The effect of dramamine upon postoperative nausea and vomiting; a controlled study of 250 consecutive surgical patients. Surg., Gynec. & Obst. **92**: 415-418, April 1951.

(From Departments of Obstetrics and Gynecology and Anesthesiology, The Hospital of the University of Pennsylvania, Philadelphia.)

In this study the use of dramamine (B-dimethylaminoethyl benzohydryl ether 8- chlorotheophyllinate) resulted in a significant decrease in the total incidence and severity of postoperative vomiting. Side actions of the drug appeared to be minimal. Suggestions as to the possible pharmacologic mechanism involved are given.

Meurers, Margot: Zur pathologisch-histologischen Diagnostik der Desmoide und der desmoidähnlichen Tumors [Histopathological diagnosis of desmoid tumors and tumors resembling these]. Zentralbl. f. Chir. **76**: 354-368, 1951.

(From Pathologischen Institut, Universität Bonn (Rhein).)

Thirty-five test excisions suspected of being fibromas, sarcomas or desmoid tumors were studied for the purpose of differentiation of true desmoids from similar tumor formations. The desmoid tumors seemed to be true tumors of benign character according to the histological picture. However, this evaluation does not agree with the clinical picture in all cases, since these recur and according to their location have clinically malignant consequences. For example, they injure the function of some muscle groups. Therefore prognosis must always be made with reservations.

Spain, D. M., Bradess, Victoria A., and Eggston, A. A.: Alcohol and violent death; a one year study of consecutive cases in a representative community. J.A.M.A. **146**: 334-335, May 26, 1951.

(From Office of the Medical Examiner, The Department of Laboratories and Research, Westchester County, New York.)

A one year study in a typical community revealed that ethyl alcohol was a contributing or responsible factor in 68 (27 percent) of 246 consecutive cases of violent death.

Farnsworth, Edith B.: ACTH and the kidney. Illinois M.J. **99**: 263-264, May 1951.

(From Northwestern University.)

ACTH affects the tubular excretion and reabsorption of several metabolic products in fairly consistent directions. The changes vary from person to person, however, and in the same person at different times. In acute or subacute diffuse glomerulonephritis, the corticoids released by ACTH often profoundly reduce the inflammatory reaction. In the nephrotic syndrome, particularly in children, ACTH sometime during the course of repeated administrations or following withdrawal will give rise to a marked diuretic response with clinical improvement. The duration of complete remissions, as well as the further treatment of partial remissions, are problems which future experience may be hoped to solve.

Rappaport, H., Raum, Muriel, and Horrell, J. B.: Bone marrow embolism. Am. J. Path. **27**: 407-426, May-June 1951.

(From Armed Forces Institute of Pathology and Veterans Administration Hospital, Washington, D. C.)

Clinical data and histologic observations in 27 cases of pulmonary bone marrow embolism indicate that embolization of marrow fragments occurs as a consequence of fracture-producing trauma to red marrow-containing bone. These fractures need not always be the result of external injury, but may be due to sudden violent muscular contractions as they occur in convulsions from any cause. In a survey of more than 200 cases of accidental death with fractures, pulmonary bone marrow embolism was found in 13, or 6 percent. Bone marrow embolism may or may not be associated with fat embolism. There was no direct correlation between the severity of fat embolism and that of bone marrow embolism in the series of cases reported.

Menten, Maud L., and McCloskey, G. A.: Histopathology and etiology of pneumonia in children dying after antibacterial therapy. Am. J. Path. **27**: 477-491, May-June 1951.

(From Department of Pathology, University of Pittsburgh School of Medicine and Children's Hospital of Pittsburgh, Pittsburgh.)

Lungs of children dying with pneumonia after receiving adequate antibiotic treatment contained few or no bacteria. These abacterial lungs showed extensive cellular hyperplasia of the alveolar walls and few or no neutrophilic leukocytes. The bronchi and bronchioles were free from involvement and appeared normal. The etiologic agent may be a virus.

Robb, Jane Sands, and Turman, W. G.: A study of Bazett's "K" after acute exercise. J. Insurance Med. **6**: 47-50, March-May 1951.

(From Department of Pharmacology State University of New York, Medical Center, Syracuse University.)

Four individuals with no history of predisposing disease, no known heart disease and obviously physically fit and four other individuals not physically fit were studied. The results are discussed, and conclusions are drawn from these.

DuShane, J. W., and Hartman, Evelyn E.: Galactosemia in infancy; report of a case with observation for 24 months. Pediatrics, **7**: 679-683, May 1951.

(From Mayo Foundation.)

This uncommon disorder of carbohydrate metabolism characterized by the inability of the body to utilize ingested galactose is described and discussed with report of a case.

McCulloch, W. S., Carlson, Helen B., and Alexander, F. G.: Zest and carbohydrate metabolism. A. Res. Nerv. & Ment. Dis. Proc. (1949) **29**: 406-411, 1950.

(From Department of Psychiatry, University of Illinois College of Medicine, Chicago.)

Responses to intravenous glucose were determined in 27 patients complaining of loss of zest and compared with 21 normal individuals on nearly the same diet. Blood sugar was measured at intervals of 5 and 15 minutes in healthy nurses and interns at rest, watching a moving picture and playing games (often chess). It was found that interest in movies and games, although it does not alter the average blood sugar level, increases the amplitude of its momentary fluctuations. Want of zest, characteristic of cases of vegetative retreat, leaves the blood sugar level normal but causes a more rapid and significantly more profound fall on injection of glucose. This cannot be attributed to increased sensitivity to insulin, for unlike average miscellaneous neurotics, these patients respond only normally to insulin. Because their blood sugar tolerance curves can be rendered normal by atropinization, it is likely that their vagoinsulin mechanism is overactive. Various other findings are discussed.

Serra, Catherine G.: Hemophilia. Arch. Pediat. **68:** 165-178, April 1951.

(From New York Medical College, Flower and Fifth Avenue Hospitals.)

The various theories of the etiology are briefly discussed with chief emphasis on the recent work of Quick. The diagnostic criteria are listed with emphasis on the prothrombin consumption test. Treatment is discussed, giving both specific and non-specific measures.

Kuhn, Hedwig S.: Sodium sulfacetimide in ophthalmology. Tr. Am. Acad. Ophth., pp. 431-435, March-April 1951.

The use of this drug, which has been of great value in industry, is described.

Kirchbaum, F. M., and **Kuhn, Hedwig S.:** Review of court decisions in eye injury cases. Tr. Am. Acad. Ophth., pp. 436-440, March-April 1951.

Twenty cases are described.

Rubin, A., Winston, J., **Metz-Rubin, Helen,** and Berwick, L.: The vestibular responses to turning, with nomograms for the detection of streptomycin and other drug toxicities and for the prediction of the normal variations of nystagmus and vertigo. Ann. Otol., Rhinol. & Laryng. **60:** 108-116, March 1941.

(From Department of Pharmacology, the Neuro-otology Section of the Department of Otolaryngology, School of Medicine, University of Pennsylvania and Department of Anesthesiology, Hospital of the University of Pennsylvania, Philadelphia.)

Normal Barany test values for the duration of postrotational nystagmus and vertigo for adult males and females are presented. Nomograms predicting the normal limits of variation of the turning test responses for a given initial test result, are presented and the application of the nomograms to vestibular testing during streptomycin therapy are shown. The usefulness of nomograms in recognizing streptomycin toxicity before the onset of vestibular symptoms is demonstrated. It is suggested that the effects of other drugs upon vestibular function might be similarly evaluated.

Lowman, R. M., **Grant, Constance,** and Losasso, D. A.: Roentgen demonstration of Ascaris lumbricoides in the alimentary tract. Connecticut State M. J. **15:** 467-469, June 1951.

(From Department of Radiology, Grace Unit, the Grace-New Haven Community Hospital.)

Roentgen demonstration is emphasized. Cases in which the method was used are demonstrated. In most cases it is not necessary to employ the roentgen methods since the diagnosis may be made by stool examination. Any method to substantiate the diagnosis of ascariasis, however, should be utilized.

Langston, W. G., **Hood, Marianna,** and Newsom, A. A., Jr.: Enterogenous cyst complicating pregnancy. Am. J. Obst. & Gynec. **61:** 1175-1176, May 1951.

(From Baylor Hospital, Dallas.)

A case is reported with histological description of tumor, which was removed. The subsequent course of pregnancy and labor was uneventful.

Hallum, Jean L., and **Newham, Ethelwyn M.:** Antenatal thrombosis. J. Obst. & Gynaec., Brit. Emp. **58:** 278-281, April 1951.

(From Sorrento Maternity Hospital, Birmingham.)

Five cases of antenatal deep thrombophlebitis are described, one complicated by anemia. In one case at the beginning of labor, several pulmonary emboli occurred with severe cardiac failure. The resultant morbidity is stressed.

Katan, Anny: The role of "displacement" in agoraphobia. Internat. J. Psycho-analysis, **32:** (1); 41-50, 1951.

A case is described, discussed and compared with similar cases.

Constable, Kate: Artane in the treatment of Parkinson's disease. Med. Illustrated, **5:** 217-224, May 1951.

The results of the use of artane on 117 patients followed for 3 years are summarized and tabulated. The results are compared with those obtained with other drugs.

Doshay, L. J., and **Constable, Kate:** Newer drugs in the treatment of Parkinsonism. Neurology, **1:** 68-74, Jan.-Feb. 1951.

(From Vanderbilt Clinic, and Neurological Institute, Department of Neurology, College of Physicians and Surgeons, Columbia University.)

The new synthetic, artane, has proved to be more effective and less disturbing to patients with parkinsonism than any of the six standard plant extracts and far less disturbing than other synthetic drugs. It is gentle in action and safe for young and old, the invalid and the ambulatory, and even among those suffering from hypertensive, renal and cardiac disorders. It is of special value in arteriosclerotic and idiopathic cases although it has proved useful in post-encephalitic cases as well. The antihistaminic, benadryl, is helpful in the control of tremor and is well tolerated by many patients in small doses. It has proved to be a good adjunct to artane or the belladonna products in cases where hyoscine is poorly tolerated, or in cases where hyoscine has lost its effect through long use. Diparcol is of value in a limited range of cases but its production is being discontinued by the manufacturer. Parpanit is too toxic, but can be used as substitution therapy in selected postencephalitic cases. Theophorin is another antihistaminic that has shown fewer advantages than benadryl. Although artane stands out supremely among present remedies, it is hardly the end of the search.

COMPLETED MEDICINE—REHABILITATION*

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Lowman, E. W., Rehabilitation of hemiplegic patient, J.A.M.A. **137:** 431-436, May 29, '48.

Rusk, H. A., Rehabilitation of hemiplegic patient, New England J. Med. **243:** 690-693, Nov. 2, '50.

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Weaver, P., Physical therapy management of lower extremity amputees, Physiotherapy Rev. **27:** 3-9, Jan.-Feb. '47.

Brunnstrom, S., Walking training of amputee: some biomechanical considerations, Physiotherapy Rev. **27:** 147-155, May-June '47.

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Seeley, J., High double arm amputee, Kessler Institute for Rehabilitation.

Anslow, R. J., Blinded bilateral, Kessler Institute for Rehabilitation.

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[5]Spinal cord injuries, Veterans Administration Technical Bulletin, TB10-503, Dec. 15, '48.

Newman, L. B., Rehabilitation of patients with spinal cord injuries, Arch. Phys. Med. **28:** 85-93, Feb. '47.

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Activities of daily living chart, Hospital for Chronic Illness, Rocky Hill, Conn.

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*Concluded from page 13

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EDITORIAL FORECAST

February 1952

Since the President of the United States has proclaimed February as National Heart Month, the JOURNAL will present several articles stressing therapy of diseases of the cardiovascular system:

"Evaluation of Newer Agents in the Treatment of Cardiac Disease," by *Estelle E. Kleiber, M.D.*, New Brunswick, New Jersey.

"Management of Heart Disease in Pregnancy," by *Miriam Butler, M.D.*, Philadelphia, Pennsylvania.

"Recent Advances in Cardiovascular Disease," by *Teresa McGovern, M.D.*, New York, New York.

"Fluid Therapy," by *Esther M. Greisheimer, M.D.*, Philadelphia, Pennsylvania.

Among the special articles will be one on "Pioneer Medical Women of the Netherlands," by *Cornelia de Lange, M.D.*

The March JOURNAL will be the second special Branch Number, and the articles will be supplied by Branch Two, Chicago, under the editorial supervision of *Dr. Ethel A. Chapman.*

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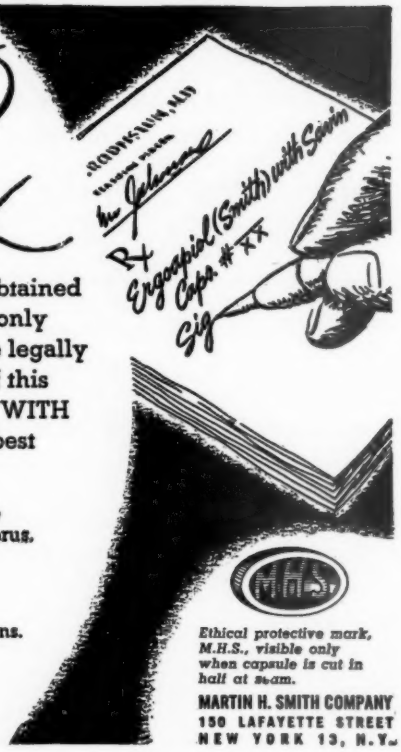

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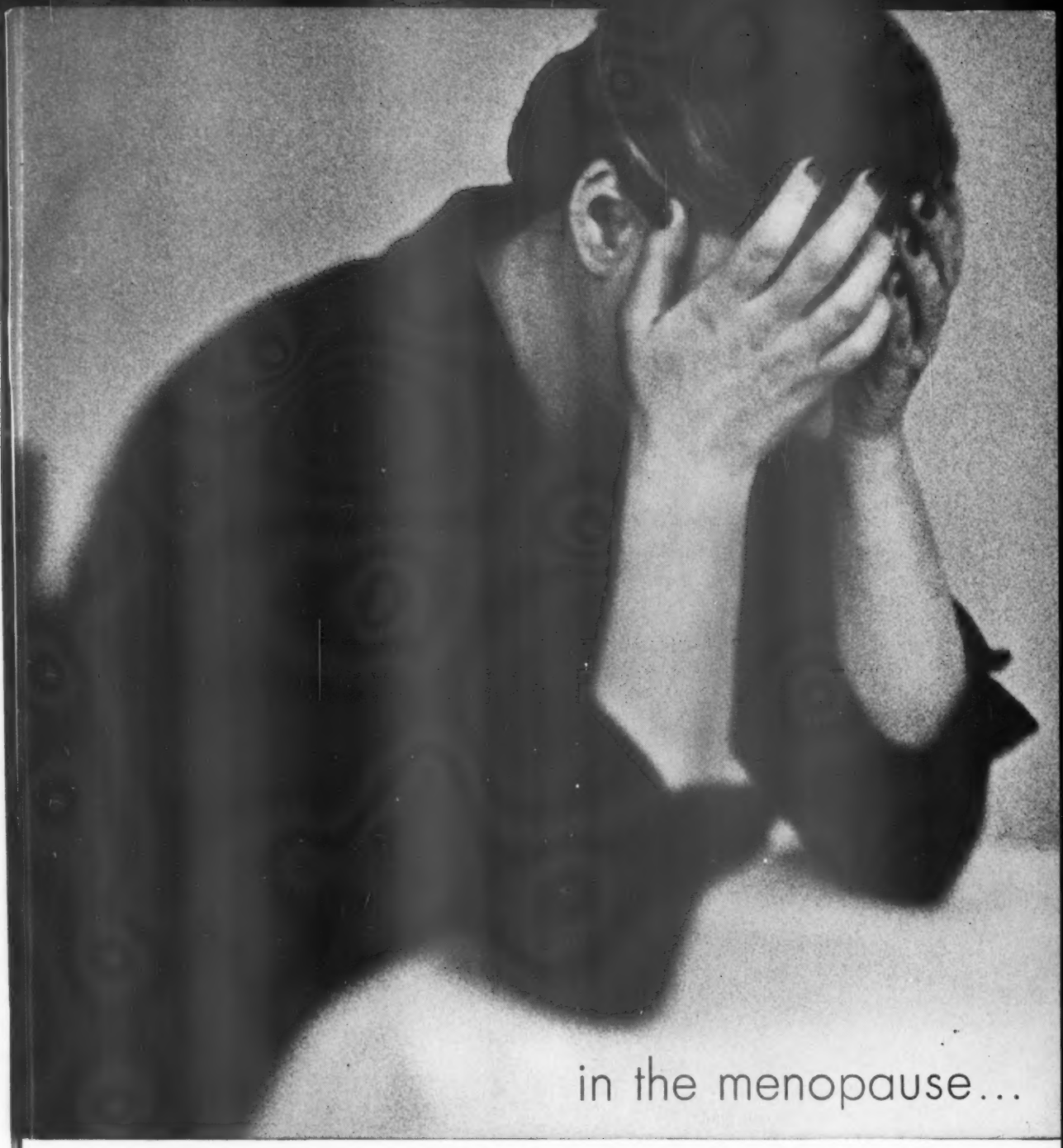
Checks payable to the American Medical Women's Association, Inc., must accompany application. Mail to Treasurer, A.M.W.A., Box 98, Madison Square Station, New York 10, N. Y.



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Neustaedter, T.: Am. J. Obst. & Gynec. 46:530 (Oct.) 1943

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1. Heimer, C. B., Grayzel, H. G., and Kramer, B.: Archives of Pediat. 68:382, 1951.
2. Behrman, H. T., Combes, F. C., Bobroff, A. and Leviticus, R.: Ind. Med. & Surg. 18:512, 1949.